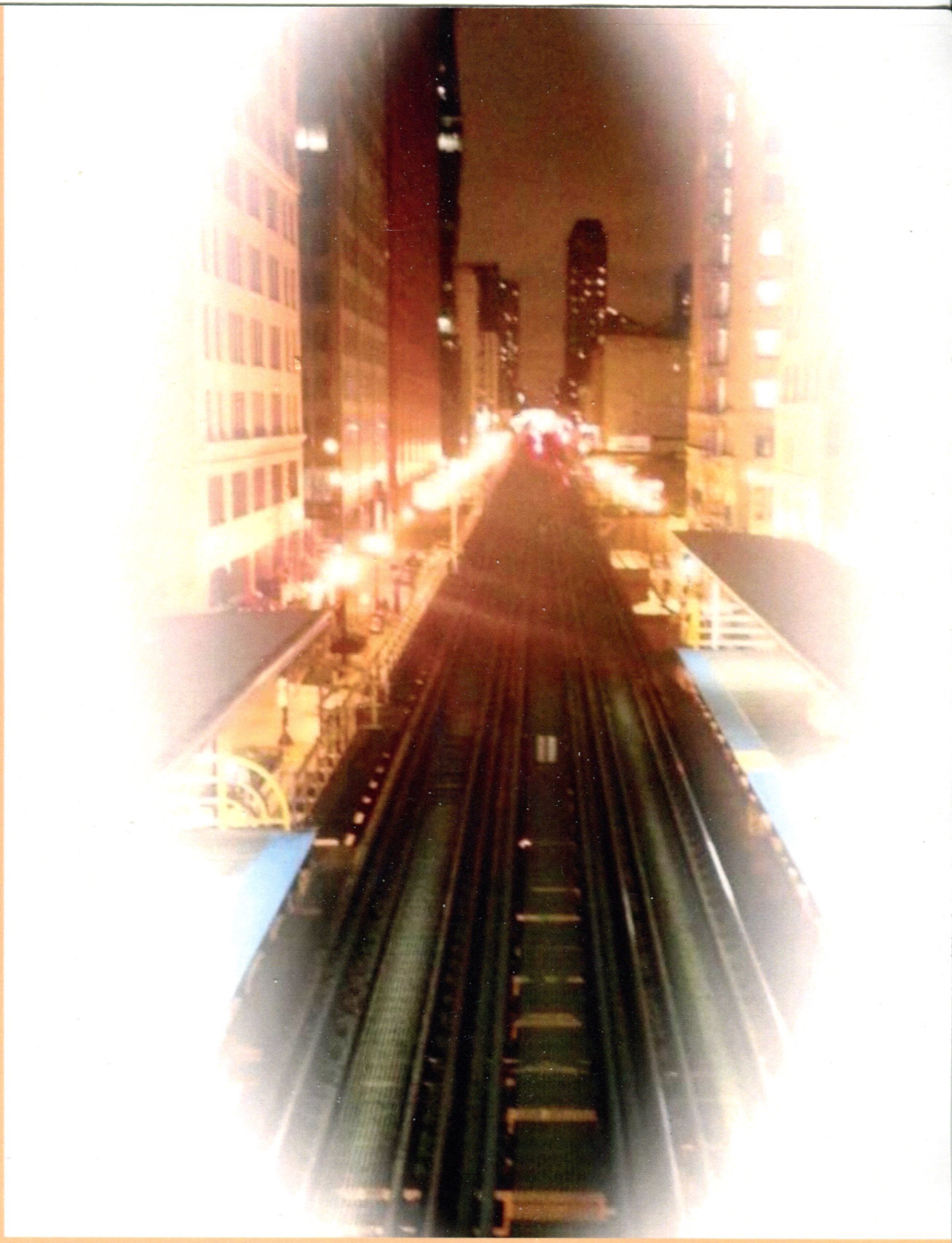
Chris Docker

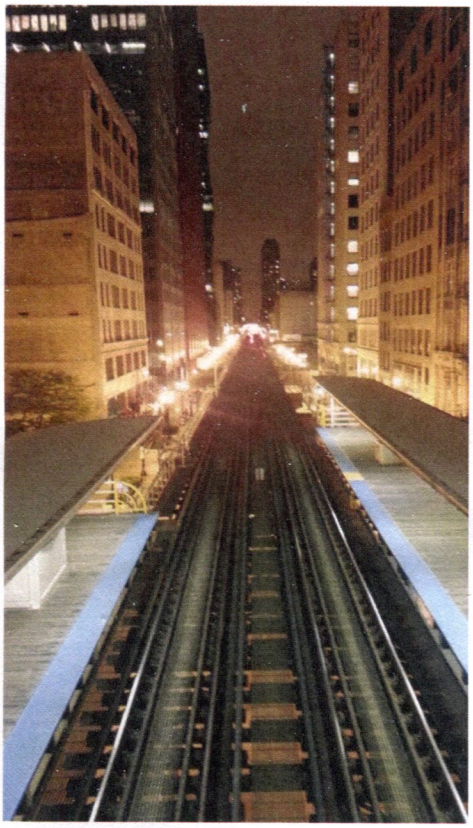
self-euthanasia, methods & dialogues



New Methods, Dialogues, & Ways Forward

Notes from a Nu-Tech Seminar

(Rational suicide for the terminally ill)



Chicago L-train. Sometimes light at the end of the tunnel is surprisingly on the top of the tunnel

CONFERENCE NOTES Suggestions for development: self-deliverance methods & dialogues

Chris Docker

(This rough paper is offered as some suggestions for your possible consideration, while highlighting a few areas for potential further work, singly or jointly. It is based in part on the seminar I gave at the *NuTech Conference* in Chicago, extended in friendship, and expanding some sections that would have been limited by time and format. The seminar particular looked at some possible causes of failure and how to overcome them. Your feedback and comments will be warmly welcomed, as well as further suggestions for development of these ideas and self-deliverance methods.)

INTRODUCTION **2**
DEVELOPING COOPERATIVE DIALOGUES 3
Productive vs intractable argument 4
Scientific method (Popper) 8
Critique a method, not the origin 8
Networking, Dissemination & Transmission 9
THE CHICAGO SEMINAR – IDEAS AND SLIDES **14**
Self-deliverance philosophy 15
EXAMINING METHODS OF SELF-DELIVERANCE 16
Helium *20*
Ligature compression *25*
Fringe methods *28*
Starving one's body of food and liquids 28
Hydrogen sulphide 30
Firearms 30
Plastic bags and drugs *31*
NEW IDEAS AND SUGGESTIONS FOR FURTHER RESEARCH 33
Solving puzzles *33*
Other avenues *34*
The moment of death *34*
HAND-OUTS (1) ANTI-EMETICS **37**
HAND OUTS (2) COMPRESSION **40**
INDEX **44**

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Introduction

Dear Friends, Colleagues, Fellow Researchers,

It is a great honour to present at the recent NuTech Conference. There is such a wealth of enthusiasm for finding desperately needed solutions, much varied talent, and it is a remarkable accomplishment that Derek and others have achieved in setting up such a Foundation.

It was a pleasure to see some of you at the recent conference and I only wish there had been more opportunity and time to enjoy conversation and discuss our serious challenges in detail. I am excited to read your latest material, whether presented at NuTech or elsewhere, and exchange ideas with you in an atmosphere of mutual support which is partly, I think, one of the aims of NuTech. I didn't manage to attend many sessions where you maybe spoke as I was working on my own seminar[1] till the last minute, my apologies, and I also wanted to present fresh, rather than simply responding to other important items that were doubtless being raised.

But what of the future? The issues facing us are still as critical as they were in 1999, when NuTech was formed. The issue of dying well or dying badly is still as crucial and emotive. Work on methods and disseminating methods has become more specialized and with increased communications more accessible. Yet there is still much work to do, not just on methods of self-deliverance but the way we organize such research. The consequences of error are great.

In 1998 a study[2] was made of another life-and-death area, how to pilot aircraft in today's hectic airspace where mistakes are fatal, and the questions asked, how could improvements made in that field be transferred successfully to healthcare. The researchers found that with increasing specialization came an increasing need for teamwork; that working effectively in teams required specific knowledge, skills, and attitudes. The 'KSAs' they developed would go on to optimise beneficial outcomes in many environments and minimize failures. They evolved into principles of teamwork as an essential component of high-reliability organizations.[3] This paper will attempt to examine and clarify some relevant KSAs.

The long-term success of NuTech, it seems clear to me, will rest on more than the isolated efforts of small groups of individuals or isolated research. While it is important to share ideas, it is also important to nourish an environment where ideas can reach fruition in a safe and reliable way. Not for the benefit of you or me, but for generations of people who desperately need the reassurance and reliability that such knowledge can bring. So before examining current issues in the methods of self-deliverance I seek your indulgence to maybe consider how we can develop ways of working to achieve the best results both now and in the future.

After more than 20 years in the field it has often come to my attention that, although the will is there, cooperative effort is often a bit hit and miss. So I looked into the latest research on this, asking myself, how can we find the most effective way forward? (As a small token of goodwill, Exit/we/I have placed a fairly large body of citations in different categories online, based on the 1000 or so citations from *Five Last Acts – The*

Exit Path; yet I realize goodwill alone does not necessarily lead to new discoveries! Yet it may save a little time for other researchers.[4])

First of all, this paper won't be able to suggest a foolproof method of healing all differences, guaranteeing perfect cooperation, or producing such cooperative effort that will result in a breakthrough next week or next month: but it is my hope that it will be a start. If others can add to it or improve on it, all to the good!

Developing cooperative dialogues

Firstly, I've drawn on two principle (philosophical) works here which make a remarkable contribution: one is a paper I came across called *Critical Thinking and Intractable Disagreement*[5], and another is a book along not dissimilar lines entitled, *Cooperative Argumentation: A Model for Deliberative Community.* [6] Whether working collaboratively or within the wider self-deliverance community I hope some such ideas as these can help us to be more effective. However, I know that while some of you may have a taste for philosophy, others, perhaps a majority, do not: so I shall try to keep the ideas straightforward and bearably brief!

There is a great temptation in the movement to say we are all friends and we all agree and share the same goal when in fact we don't agree on all things; even quite important ones. It is essential, for the people that rely on our work, to develop structures that allow us to examine differences harmoniously. We are all pointing broadly in the same direction, true, but it is in the recognizing of our differences that *effective* deliberative discourse can also occur. If we are too intent on ignoring differences, they can surface at a time when it is harder to deal with them deliberatively. Instead of repressing differences, we should rejoice in them, so that different approaches augment and refine each other rather than vie for position.

An audience member instinctively grasped a fundamental of my approach when she commented afterwards, "Your seminar was different in that so many other speakers all spoke as if they had *the one* answer, whereas you began by pointing out that even though your books on self-deliverance might appear encyclopaedic[7], that could never be the case, as there is always more that we need to know." This has always been the position. No method of self-deliverance is 100% effective for 100% of the people who attempt it. All we can do is try to get the effectiveness increasingly closer to 100%.

What I am working towards here is an approach to cooperation that is rooted in scientific method (and by which I include effective social science) rather than such things as friendships or chance meetings over coffee alone. It might be great if we could all get together and brainstorm our ideas and hypotheses and our data and evidence every afternoon, but even meeting once every two years is almost prohibitively expensive! If we work in isolation, or comparative isolation, then we are working with limited review process, and possibly in ignorance of conflicting data from others elsewhere.

At the bottom of this, people's lives are at stake. People dying badly even though they have read the literature may be few in number, but even one is too many. Our *common* aims are to reduce the number of bad self-deliverances. This is the ultimate goal. Not a scientific breakthrough; not a better book, journal paper, or video than last year; not our name in lights or an award at the WFRTDS Gala. But *to reduce the number of bad deaths.*

But one might say, "Surely that is obvious! We don't do this work for any other reason!" Yet I hope to convince you that discovering and magnifying this commonality is indeed not only essential but at the forefront of effective development.

Productive vs intractable argument

To explain this, I shall refer to Dale Turner's differentiation of arguments that lead to a *productive conclusion* versus arguments that appear *'intractable.'* (Before we dismiss it as unnecessary, let's maybe remember that there are many intractable arguments affecting this movement: the argument, for instance, between those groups working for legislation (to help persons die better in the future) and those working for self-deliverance (to help people *now:* or for whom legislation will come too late). We could even include the 'right-to-die' vs the 'right-to-life' or 'palliative care' movements (and isn't the affording of assisted suicide in Oregon hospitals an excellent example of resolution? Both groups share at least a quasi commonality of interest in the best interests of someone's life before death; whereas some *faith-based* issues might be completely intractable.)

Effective communication and deliberation often breaks down when differences that are resolvable and very productive (normal arguments) falsely appear to be intractable arguments.[8] What is the basic difference between the two types of arguments? Consider this:

A person is asked why he is taking a particular road and he replies, "I want to pick up the fish last." We can imagine this being a conclusive answer. On the other hand, it might be met with the rejoinder, "No, go to the Grand Union last; I don't want the ice cream to melt." This too might be conclusive.[9]

What are the unspoken assumptions? We might deduce that the conversation is between two friends; but the real (determinative) issue is that they probably both have a common interest in enjoying the fish and the ice cream at the best that they can be. This common interest means they allow it to *override* such things who is "right" or who had the last word.

It could go further: the first person might point out that the traffic that way is horrible this time of day, and it would be better to wait a bit to let it clear out. There is also an urgency to their discussion. If they don't resolve it efficiently, they will have a poorer chance of getting the food back home in the best, most usable, condition.

I think there is maybe a fairly close parallel here to our research into self-deliverance: we need to get our effective communications working quickly, otherwise the likelihood of even a small number of persons dying badly is increased.

The persons in the hypothetical argument just examined reach a best (or 'least worst') conclusion quickly because they focus on their *unspoken* shared beliefs and (where these are different), shared preferences. They share a detailed knowledge of local geography, preferences for frozen ice cream over melted ice cream and fresh fish over stinking fish, and so on. An important feature of these shared beliefs and preferences is that they lie in the background, unmentioned. They guide the discussion, but they are not the subject of it. They provide a framework or a structure within which reasons

can be marshaled, and where marshaling reasons is typically a matter of citing facts that others already know or of arranging facts in a way that their significance becomes clear. Most importantly, they are not defending a position but more interested in improving on their deliberations.

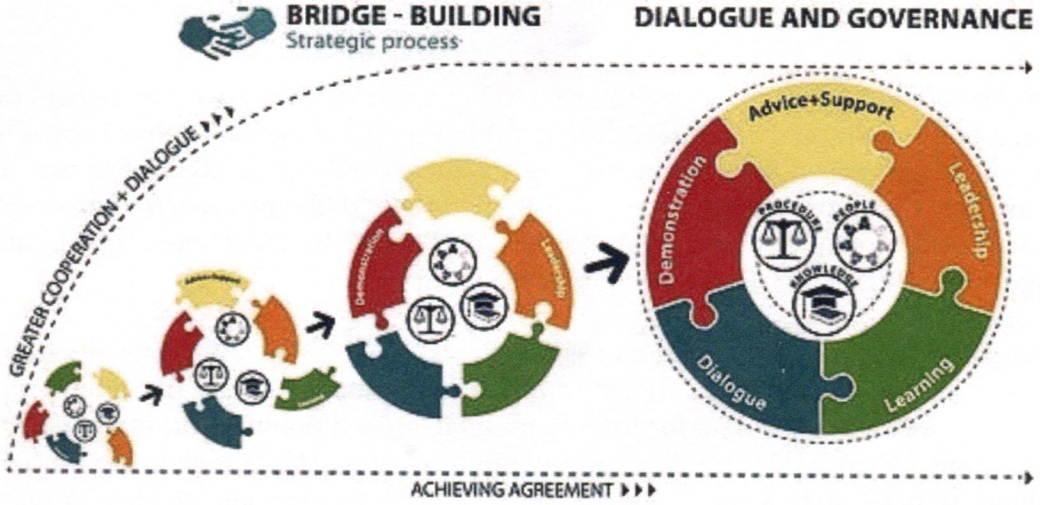
Unfortunately in real life, especially when time, distance and a host of other things come into play, staying focused on a shared effort can become more difficult. There may be (for instance) a pressure to publish (and get the information to those who need it), or a pressure to get on with other things. There may be errors of analysis, errors of translation and understanding, or errors of dissemination, all of which potentially reduce the effectiveness of attempts to reduce bad deaths.

Some of the arguments about self-deliverance methods are now quite highly technical arguments, which presents us with another major factor. As Fogelin expresses it:

> Hume saw long ago (in his discussion of *Unphilosophical Probability* in the *Treatise*[10]) and as cognitive psychologists have rediscovered, human beings seem to be endowed with innate capacities for messing things up as soon as argumentative structures rise above the simplest level of complexity. (This is particularly true of inductive inferences where, for example, the tendency for hasty and unfounded generalization[11] seems to be hardwired into the human brain.)

One way we avoid hasty generalizations is to use phrases like, "in some known cases" or "in many / a majority of cases" (if it is the case). In proving an argument, the most important stage is trying to disprove it, to see the possible flaws, and in self-deliverance technology so to see the possibility of failures before they occur (the same laws of evidence and avoiding hasty generalizations also apply to disproofs!)

Other common fallacies seen both within and aimed at our movement include the fallacy of *jumping on the bandwagon* which means something is right because "everyone says it is" or because it is a popular belief. For example, "many people are using hydrogen sulphide to kill themselves, so it must be good." (The same could be said for hanging or paracetamol/acetaminophen – neither of which offer a reliably painless death.) But to say that a method is bad because "the wrong people" use it (such as mentally unbalanced people rather than the RTD 'target' population) is also a fallacy,



What do our organisations aim to do? For whom? In what way? Is there a structure for them to interact efficiently and with each other? What, and who, is NuTech?

a variation of the *ad hominem* argument, criticizing the persons rather than a method which is potentially independent of them.

We perhaps also have to face the fact that we are fallible; and simply try to be a little less fallible. At Exit,[12] I am comparatively fortunate in that our number one priority and reason for existence (since 1980) is research into self-deliverance. This is mostly based on data research, often thousands of pages of it, plus peer review or occasionally seeking expert clarification in an area where there are few experts or published facts (one such case being the question of fatal brain haemorrhage / anoxia in cases of ligature compression suicide vs the very occasional case of PVS in attempted ligature compression by a third party, which has never occurred in the extensive known statistics for the former). There is no pressure to publish, as there is in academia,[13] no pressure to be a "highest authority" as doctors tell me there frequently is in medicine, and no pressure to get on with the rest of the "club" (meaning the World Federation, of which Exit has been gently but openly critical). We have a freedom to seek better answers; but the downside is comparative isolation from other workers in the field, many of whom could benefit from our work just as we could benefit from their collaboration: yet the real benefits, *the only ones that count,* are benefits to people relying on us and others in the self-deliverance community for answers to help them in their final moments. That is what I believe we need to focus on to improve collaboration or cooperation among those of us working in this field.

While this might sound like a platitude, it would appear to be a principle element of the necessary commonality discussed earlier in this paper that is the basis for productive 'normal' argumentation and deliberation that leads to useful development as opposed to intractable arguments. (Another is scientific method, which I will come to presently.)

A common problem for other researchers is time (although it is not unlimited, we do probably have more of it). A common problem for ourselves, Exit, if not an intractable one, is receiving well-meaning but frequently incorrect criticism. But the real losers in both cases are the people who desperately need the most reliable information on taking their own life. They are often left with partial views and come to our workshops asking why three or more different authors are telling them three or more different things.

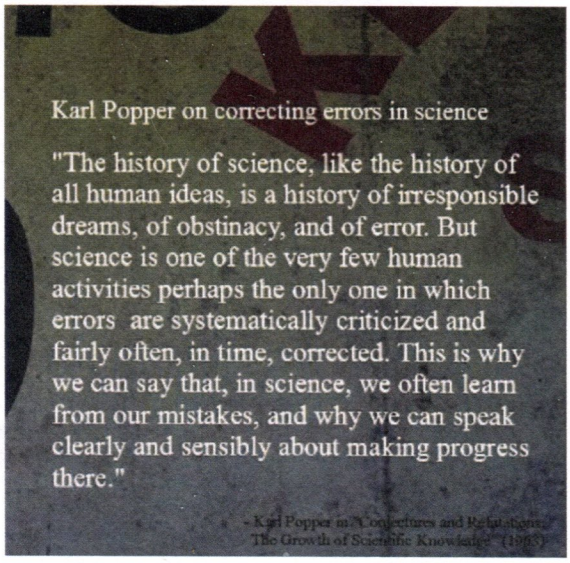
In order to handle this, we are trying to develop a format where we can incorporate, at least in our own publications, replies by other researchers when we have come to a different conclusion. Often, as in the case of the discussion involving fish and ice-cream, the sharing of criticism in good faith reveals different aspects that develop mutual understanding rather than 'pistols at dawn!' In most cases it reveals a progression rather than a "one right answer" syndrome.

A couple of positive examples might usefully illustrate this point. After our research on drugs + plastic bag asphyxia,[14] I wrote to Derek Humphry suggesting that a much larger bag would be optimum for this method. He replied pointing out that, especially at that time (when AIDS was more at the forefront as a self-deliverance issue than it perhaps is now) that a small bag was often used by persons in very desperate circumstances. We incorporated Derek's remarks into our literature. It also made us think harder about the *practicality* of the larger bag (which had a number issues when we tested it in workshops, since resolved).

Realizing that the issue of "different viewpoints" was increasingly becoming an issue for the persons whom we were all trying to help, we formalized this method when reviewing the 'flow control valve' produced by my good friend and researcher Philip Nitschke.[15] We examined the device in our office and at workshops, analyzing the science behind it as fairly as we could. Then we sent the critique to Philip for his reply, and *then published his words in full at the same time that we published our own article.* This alerted us to some potential benefits we had overlooked, such as a sense of security that it can give some people, as well as a question about our own methodology. In workshops, the question of adjusting flow from a helium tank is a very minor issue, partly due to the popularity of a cheap and simple Swedish tap-turner (clearly the best solution as far as we can see): yet although we have recommended this to other societies we are not aware that other societies have even tried it. We have little in the way of marketing and are not set up to supply them by mail order. All we really do is research data and publish documented information. It was a partial step forward: readers were not left wondering if different authors actually ever spoke to each other!

A slightly more difficult area is when a clear error of judgment has been made resulting in one or more bad deaths. A public 'response' can do little to ameliorate the harm or suffering that has occurred. Yet such errors could a) easily, and most probably, have been made with good intentions, and b) if persons or groups are criticized to roundly they will become reluctant to share crucial information. (In the seminar) I used examples of failed self-deliverance attempts that we can learn from, without accusing people by name. This hopefully might allow us all to focus on improvements without unproductive finger-pointing.

At this point it is probably worth acknowledging differences. Not in a judgmental way but simply to recognize that we all have valid differences in who we are, what we do, how we do it, and the interests, beliefs and preferences within which we individually work. It may be necessary to recognize and respect intractable differences and also separate then from productive differences. Organizations work in different ways. They have different pressures, expectations, budgets. Sometimes they have differing sets of priorities (for instance some will place a high or joint priority on legal change or publicizing RTD issues). Doctors will continue to act like doctors and academics will continue to act like academics. These are things that we cannot change. They could be called intractables and they include both benefits and downsides, as already mentioned. Notwithstanding this, some seeming intractables can voluntarily be modified.


Karl Popper on correcting errors in science
"The history of science, like the history of all human ideas, is a history of irresponsible dreams, of obstinacy, and of error. But science is one of the very few human activities perhaps the only one in which errors are systematically criticized and fairly often, in time, corrected. This is why we can say that, in science, we often learn from our mistakes, and why we can speak clearly and sensibly about making progress there."
- Karl Popper in "Conjectures and Refutations: The Growth of Scientific Knowledge" (1963)

An important point made by Fogelin is that while people often disagree over simple questions of fact, they can (generally) agree on the method for resolving their disagreement.[16] Where it is a disagreement on facts, we can look them up, or introduce more facts and examine their applicability. But when it comes to 'facts' and 'scientific method', some important clarifications should be made.

Scientific method (Popper)

In the seminar, I used the diagram on the following page to illustrate the common understanding of scientific method: but for serious work, it needs a bit of a shake-up.

Karl Popper (1902-1994) made 'falsifiability' the key to his philosophy of science. It became the most commonly invoked "criterion of demarcation" of science from non-science. The main problem with the simpler definition is in 'drawing conclusions.' Popper held that a theory is only scientific if it is refutable. One has to be able to try to prove it wrong. This contradicts earlier ideas where the object was to prove something right: yet Popper pointed out that we can never prove something unquestionably right since one more experiment is all that is needed to prove it wrong. Not only that, but we only learn by attempts to prove our hypotheses wrong.

Using this as the cornerstone of scientific method allows us to get ever closer to a 'true' and more effective picture. Persistent examination of failures with the plastic-bag-and-drugs allowed Exit to identify causes of failure and thus eliminate them.[17] The same is true of other self-deliverance methods.

Critique a method, not the origin

Part of the relevance of this to self-deliverance is something we know already: no method is completely foolproof (see later section). What we must do is constantly to improve methodology, and in that, sadly, one of the main teachers is failures where a method that has apparently been largely successful was used. This also presents challenges among us on the cooperative level, remembering that we are doing this work for the benefit of end-users (persons effecting their own rational suicide). None of our work can claim to be perfect. It is more efficient, more productive, to critique a formula and improve on it than it is to blame the persons who issued that formula. In the seminar therefore, and in this paper, I have cited examples of failures using different methods, citing where the error lay in the method rather than citing the persons responsible (since they will know already). A further layer of discretion is also advisable since too overt a criticism, however valuable, will create unnecessary distrust and fear among the public even if the method 99% effective!

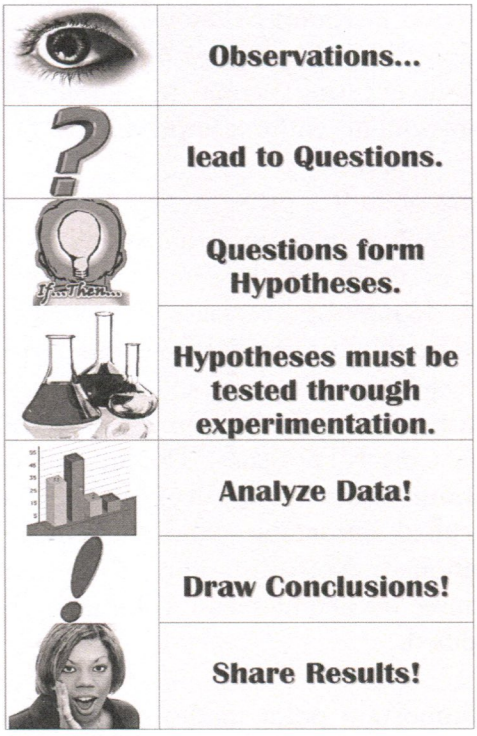


Figure 1 (old school) simplistic idea of scientific method

The above, however appropriate for the self-deliverance community as a whole, immediately conflicts with a common academic convention which is a variant on the Socratic tradition and far more adversarial: one refines one's argument by attacking

an earlier position of someone else. Although this has fallen into disrepute philosophically[18], it is tacitly supported by universities and other institutions as it is a way of reflecting an excellence upon both the faculty and the scholar (and academics tend to rise in esteem on the strength of the number of papers they have produced and had accepted). As Tannen describes:

> . . . a common framework for academic papers (one that I myself have implemented, as I suspect nearly all of us have at one time or another) prescribes that authors position their work in opposition to someone else's, which they then prove wrong. This is agonistic to the extent that it is conventionalized and prescribed. This standard framework creates a *need* to make others wrong which tempts – indeed, requires – scholars to (1) at best oversimplify, at worst distort or even misrepresent others' positions; (2) search for the most foolish statement and the weakest examples to make a generally reasonable treatise appear less so; and (3) ignore facts that support the opponent's views and cite only those that support theirs.[19]

Yet we live in the real world. There are a number of excellent academics working in the field, it could be seen as unfair to try to apply a maxim of mutual support that conflicts with their reasonable, professional career aspirations; where there is no other way open, one probably has to reply in a similar way sometimes, citing their criticisms and responding explicitly in print, since researchers need at least to be able to access the dialogue.[20] (The greater accessibility, in the professional journals, of academic papers also offers greater accessibility, through libraries and universities, thus providing a valuable source of discourse.) But where possible, I feel that it is more helpful to address the criticism without addressing the author. (In journals there is at least the possibility of continuity, likewise in departmental colloquia, but generally absent otherwise.) One of my own personal challenges has been not to get upset by criticisms, including ones that are completely unfounded.

It is perhaps worth referencing this as an example of the need to recognize our differences in real life (including our jobs). Different researchers and different supporters of self-deliverance all contribute in different ways, usually with the very best of intentions. Understanding this (with a spirit of generosity) and using our knowledge to help rather than criticize another group or researcher is a more productive course, wherever possible, than the agonistic one described. Even to proclaim our own knowledge as "the best" can be a flawed approach (and one I am sure I have probably been guilty of at some point) when it implies that others are somehow "wrong" (and as new data may yet come to light). The balance between critical argument that results in a positive gain for all concerned, and one where we tendentiously allow that "all methods are true" is a delicate one.

Networking, Dissemination & Transmission

Once we have a method that works, the next challenge is to see that, if it is used, it is used properly and effectively. It is as important to refine, as far as we can, our methods of dissemination as much as it is the methods of self-deliverance themselves.

In the Exit workshops, we have always had an icebreaker session where the participants are divided into smaller groups and each given a dilemma to tackle. One of those dilemmas runs something like this: "If a very ill friend asked you to let them have a quick look at your copy of a self-deliverance manual, would you?"

Most persons say yes. So then we add a sting in the tail. "What if that person then, in their haste and weakened state of mind, misunderstands the instructions and suffers a bad death as a consequence?"

Although it is a simplified scenario, the unintended consequences are frightening. Let us consider two actual examples of errors in dissemination. These are sensitive issues, so must try to be sensitive but also examine them and ask how errors could be avoided in the future.

But before doing that, I'd like briefly to consider one of the most successful methods – helium. Can anything be learnt in the *transmission* of data that could apply to other methods? Although there are cases of failure with helium, they are very rare; this has probably encouraged greater dissemination than with other methods, widespread discussion (generally with agreement on main essential points). There are now many video presentations available from different sources. As a method of painless suicide, it has probably featured in academic journals more than other methods (with the possible exception of barbiturates). This points to widespread integration. At the seminar, I asked, "Can I assume everyone is more or less familiar with the 'helium method'?" and there was general agreement that the audience was indeed familiar with it.

If we turn now to cases where there have been errors of dissemination, we may see that the absence of widespread integration (of relevant knowledge) was almost undoubtedly a defining factor, and by identifying this as an area we can look at it for possible improvements. Both cases involved complex methods and it may be objected that we should stick with helium as it is (relatively) straightforward and successful: yet I hope to show later in this paper that there are occasions where helium is *not* appropriate and that it is prudent to be armed with more than one method.

In the first of our two cases, Exit was intimately involved and is deeply aware of the worry occasioned to all parties when the error was discovered. In the second case, it concerned two third parties, and so although solutions for similar situations may more be sought by those involved, perhaps the first case may be illustratively helpful and also, in looking at the two cases together, ideas for general principles might be stimulated.[21]

In 1993, Exit distributed the text of a carefully researched self-deliverance booklet free of charge to several other countries on the strict understanding that translations would not change the meaning of any text. (Contracts were even drawn up to this effect.) Many years later it was discovered that, in one country, a drugs recipe had been changed, and documented disastrous results had now come to light. The method involved was chloroquine-plus-sedatives. This method has been controversial for more than 20 years (largely due to the complexity of the pharmacokinetics[22]) but is still successfully employed, particularly in Germany.

Exit's first reaction was a measure of outrage: after all, a legally binding agreement had been broken (by someone, but now many years previously). Legal action was even considered but not implemented, although it perhaps highlighted the seriousness of what had happened. Unfortunately the more 'successful' any research is in being taken up by other organizations, the greater the possibility of something bad

happening, even if the research is sound and the researchers are working steadfastly and accurately. Why is this? Apart from the sheer numbers, a researcher (a group of researchers) can never be sure that their supporters will be as steadfast and accurate as they are, or acting with the same probity. Laxity may occur as things are filtered down. To play the 'blame game' against the offending organization would only address that single situation (and even that inadequately, as it is too late): the more efficient course is that researcher(s) continue to follow their own highest ideals of honest behaviour and ethical scrutiny, both in their work and in the manner in which that work is disseminated. (Thus one may hope that methods of dissemination will also be improved and that, by setting standards, others will follow, or at least emulate those standards.)

What else could have been done? Perhaps a deeper follow-up discussion with influential persons in the recipient organization, or a fuller awareness of the differences in the situation of the recipient country. When medical persons are present, it is particularly important to go over the fine technical detail (At the seminar, I provided a second set of hand-outs for those with a medical background[23]). This is because in highly specialized areas, it is perfectly natural for a doctor to make an informed guess. We often rely on doctors to do this, and if a doctor strays outside of his or her own particular areas of expertise, their guess is still often better than that of many other people. But in cases of highly specialized work this may not hold quite so true. A way to address this is simply to *talk to medical persons in their own language*. Most importantly (following the Popper analysis of scientific method already discussed), ask:

> Do you understand how this can go wrong?

Following the example given at the beginning of this essay, that of aircraft piloting, it is not sufficient to say 'who was to blame' when an aircraft crashes and people die badly: we must have processes where there are fail-safes, and the people or companies flying and maintaining the aircraft are sufficiently familiar with the things that can wrong, and how reliably to prevent such things happening. If you are the recipient organization, it may be reasonable to start out from the point of view that the originating authors are more aware of the issues. If you have other ideas, whether of content or presentation, you might try to discuss it with them, or dig out the relevant data and research studies (both their quoted ones and a broader search since they may not have cited all their material). General enthusiasm can encourage over-attention to the positives. This is important for transmission to end-users so as not to distress them unduly (pre-flight safety demonstrations do not need to be the main topic of inflight discussion: they just need to happen).

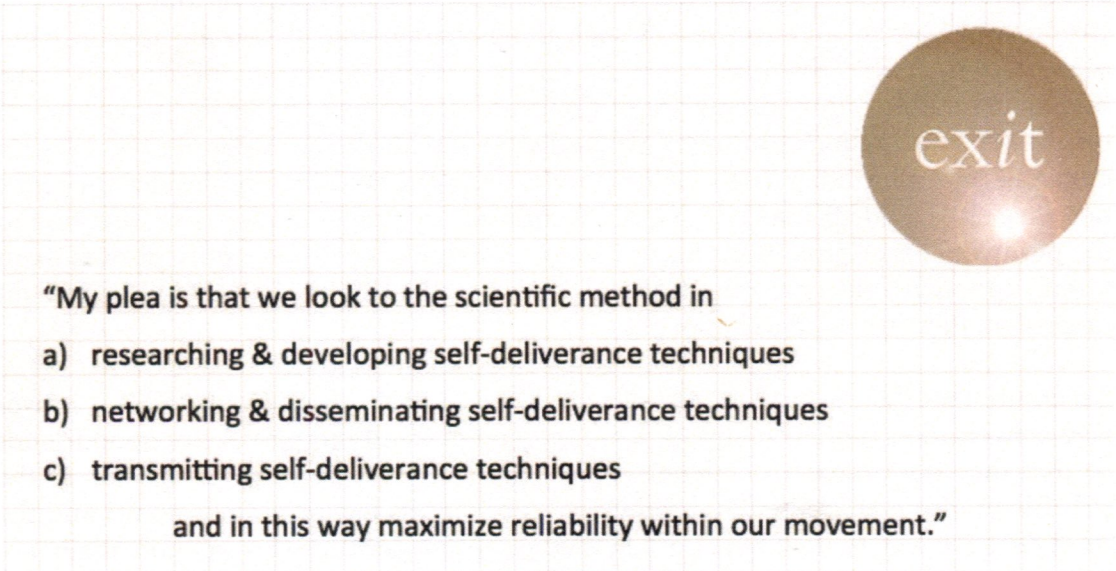
To ensure that full integration of knowledge, skills and attitudes occurs (KSAs), a two-way conversation is often required. It is not enough that both parties are good friends or that they both have an eminent record: the conversation must be specific to the self-deliverance method being disseminated, both on its technical finer points and the most effective way to then transmit the method to the persons who will potentially use it at the end of life. In real life, time pressures may all too easily deem this unnecessary or impossible, even if experience demonstrates it to be essential. Only by setting out standards to be aimed at can we at least hope for improvements in reliability of dissemination and transmission.

More recently, a second example related to some excellent Dutch research on refusal-of-food-and-liquids which was distributed semi-exclusively to a small right-to-die

group in a different country. (This is another difficult but entirely valid method of self-deliverance.) The group, with the best of intentions, then made a simplified version, again with disastrous results and documented cases of persons dying badly. One of the factors here may have been the legal and social conditions in the recipient country which were very different to the more liberal situation often encountered in the Netherlands, and which made effective and safe transmission more difficult to people who needed the information for ending their life.

With helium, we have the situation that it is not available in certain countries (just as chloroquine is hard to obtain in the U.S.A.). In most cases, this is not dangerous – people simply seek an alternative method: but in certain, less-regulated countries the helium tanks are re-filled and re-sold with highly flammable gas, gas that is cheaper than helium which works for floating balloons, but is dangerous when handled without caution. Similarly legal guidance that applies to a method in one country may not apply in another.[24]

Although *the proportion of bad deaths in each case has been tiny,* these instances highlight the need for care (and if possible, a Popperian attitude of scientific falsifiability) when distributing self-deliverance material. We learn from mistakes, and by focusing, not on the glory of our 'achievements,' but on the importance of accurate transmission of knowledge to those who need it to draw their life to a close. It brings us to the relevance of considering *attitudes* in networking and dissemination. Using the most effective principles, monitoring effectiveness over a period of time, can help our organizations and personal efforts achieve stronger reliability.


exit
"My plea is that we look to the scientific method in
a) researching & developing self-deliverance techniques
b) networking & disseminating self-deliverance techniques
c) transmitting self-deliverance techniques
and in this way maximize reliability within our movement."

A key question at each stage is: "What could go wrong?"

At (a): errors may occur due to too small a data sample, or failure to examine the method from a multidisciplinary level, errors of logic, or insufficient consideration of practical applicability.

At (b): errors may occur from non-integration of knowledge, skills and attitudes (KSAs) with a recipient organization (whose country and membership may also present unaccounted-for data, for instance due to laws or availability of materials).

At (c): errors may occur due to mental or physical infirmity, too great a complexity of the methods, or failure to anticipate problems and ways to overcome them.

Positing of error (finding ways that failure to obtain a peaceful death by the method might occur or have occurred) is a valuable tool for refining knowledge to maximize elimination of error in the future and so maximize reliability.

Cooperation requires two-way listening and respecting of differences.
Some of the foregoing proves too complex for busy people eager to "get down to business." Where there is doubt, may I suggest some quick "rule of thumb" ideas:

- **If in doubt don't say anything.** (Especially useful if wondering whether to *criticize* someone else.) This especially applies to *print* materials.
- **Use game theory / reciprocity.** Over a long period of time, cooperate first by being cooperative with *everyone* and then keep going if they *return cooperation* with you. (A 'long period,' since initial disagreements are common and often just knee-jerk reactions. Cooperation also means getting something back, not just a lot of words about cooperativeness!).
- **Be generally beneficent but within your means.** This simply means giving as much as one can afford without any expectation of return.

The dialogic approach, explained in detail in the foregoing pages, accords with these yet explains the underlying principles with examples. Please consider studying the text where serious negotiations and dialogue are likely to be required.

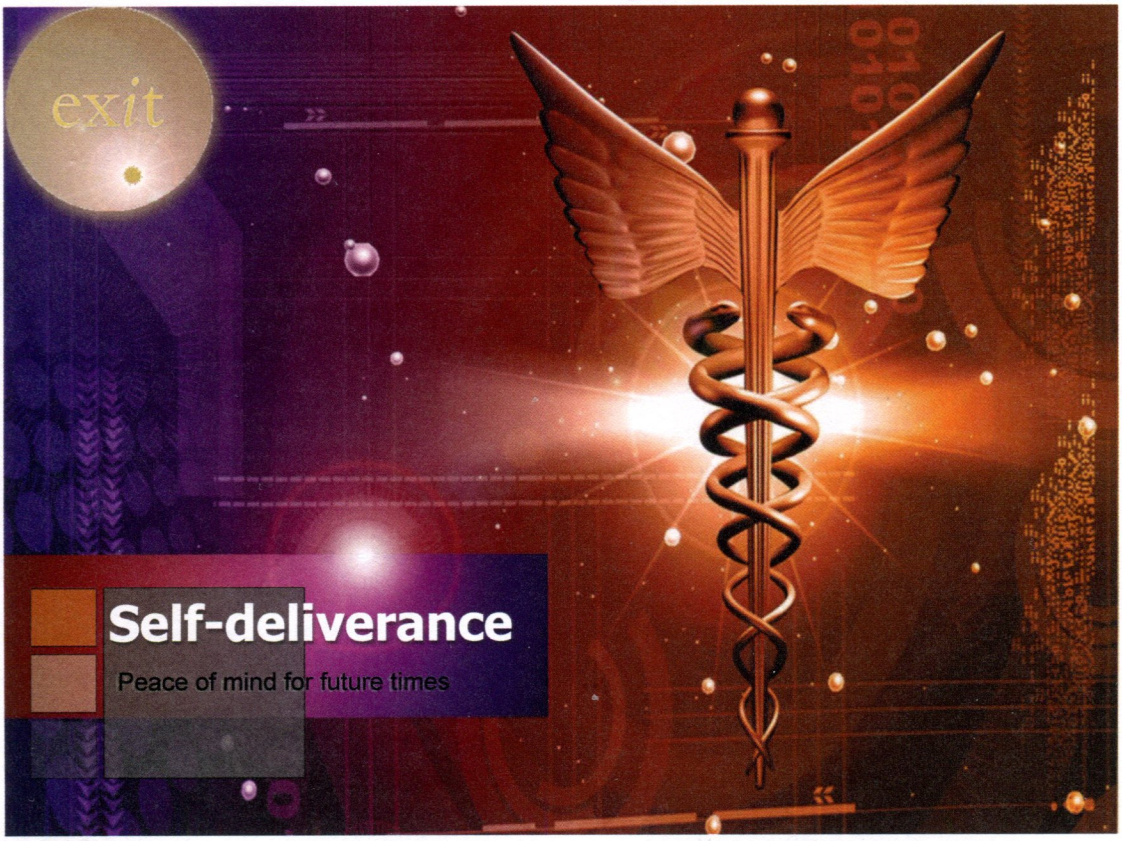
Remember:

Dialogue is listening with an open spirit.

Debate is a verbal 'fight.'

Discussion is the breaking apart of issues.

Ann McGee-Cooper



The Chicago Seminar – ideas and slides

NuTech Conference at the WFRTDS, Embassy Suites Lakefront Hotel 20 September
Chair: Derek Humphry & Faye Girsh Guest speaker: Chris Docker

"It was 26 years ago that I first met Derek, when he visited Scotland to give a talk, a talk which we published in our then very small Newsletter. We might have produced the world's first tiny suicide guide, but it was Derek who publicized self-deliverance – or rational suicide as it is also called – for millions. It is an honour to return the visit and give a talk at his inspiring way of developing things, which he calls "NuTech."

I would also like to thank Faye Girsh for her remarkable networking skills in the run-up to this seminar as I was slightly puzzled why you would invite the relatively unknown author of some self-deliverance books from a tiny organization in an equally tiny country. Derek warned me not to bring any self-deliverance equipment through customs but, being what Dick Côté[25] has called a 'feisty Scot', I did anyway. I will maybe demonstrate that later as best I can. But with an hour or so on the clock, it would be inconsiderate to die just yet; so the question I ask myself is, how can I bring value to the considerable effort you have all made to get here?

I gather from various emails that you are maybe interested in any insights from our reputedly unique style of workshops, and particularly the ligature compression technique. And then there are questions about anti-emetics, firearms and hydrogen sulphide. So we'll cover what we can and in this seminar I will aim to offer 4 Sections:

1. PHILOSOPHY. Exit believes in total clarity about what we're doing and why, so I'll try to do the same.

2. METHODS. Here I shall focus on about 5 main methods but with special attention to flaws and how to overcome them. Much of it is from my book *Five Last Acts – The Exit Path,* which includes pretty well all of the knowledge we've built up on the subject,[26] and if you are interested it can be ordered from Amazon (it will in all likelihood arrive at your house before you get home).

3. NEW METHODS. Here I will look at some ideas and new areas that in my opinion are worthy of further research.

4. PATHWAYS. [27] If we have time, I will present some ideas for your consideration on how we can maximize our efforts in this self-deliverance research.

I should, by the way, stress that I am not the founder of Exit, as mentioned in the Conference brochure. That was a misprint. I actually joined a few years later after George Mair, another 'feisty Scot', had got the ball rolling.[28]

There's a lot to get through, so I've provided some hand-outs to save you taking notes and there will also be online materials. While I am not suggesting that you, "hang on to every word," I hope we can make the subject both serious but also enjoyable.

A question I often ask at the start of our full-day workshops in the U.K. is, if you needed, for pressing reasons, to end your life half an hour from now, could you? It is a question, among others, that I hope to maybe provide you with a positive answer later in this talk, but if *you* have any burning questions, please don't go away without them being answered!

Self-deliverance philosophy

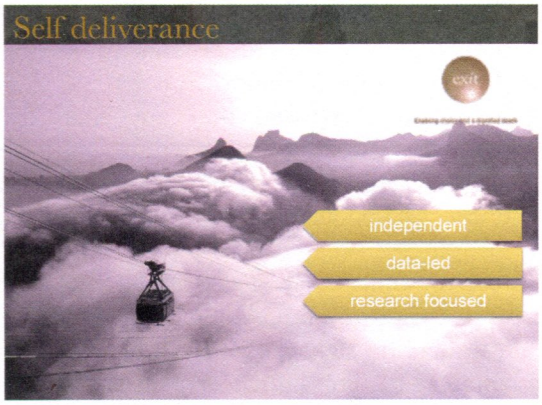
Whether one argues from a utilitarian position to maximize beneficial outcomes, along with John Stuart Mill, or with Kantian arguments of autonomy, dignity and individual rights, the same conclusion can be reached: that as long as they do not interfere with the liberty of others, people should be free to pursue their own good in their own way.

It is written that any man (by which I mean any man or woman) has the right to die when and how he will.[29] The term "right to die" on it's own is meaningless since one cannot have a right to something that will happen anyway: only a right to chose when and how. Man also has the right to assist someone else – and face the consequences. He also has the right, let us not forget, to dissuade someone else whom he feels is misguided. But the devil is in the detail!

A preponderance of World Federation organizations largely seek to persuade governments to minimize various consequences in various circumstances, but this becomes very problematic when we have to define the circumstances. [30] From the original statement I made about rights, it seems clear to me that, if someone *for whatever reason* reaches an *unshakeable decision* to end his or her life,[31] then at very least it is only decent to hope that their suffering can be minimized (an exception might be persons incarcerated in prison, where suffering is part of the punishment).

Statistically, most persons dying by their own hand suffer pain and indignity.[32] Wrong conceptions abound about 'painless' methods, and reliable ideas are individually harder to come by and to communicate. Maybe our common purpose here is not to be perfect but to be *less imperfect.*

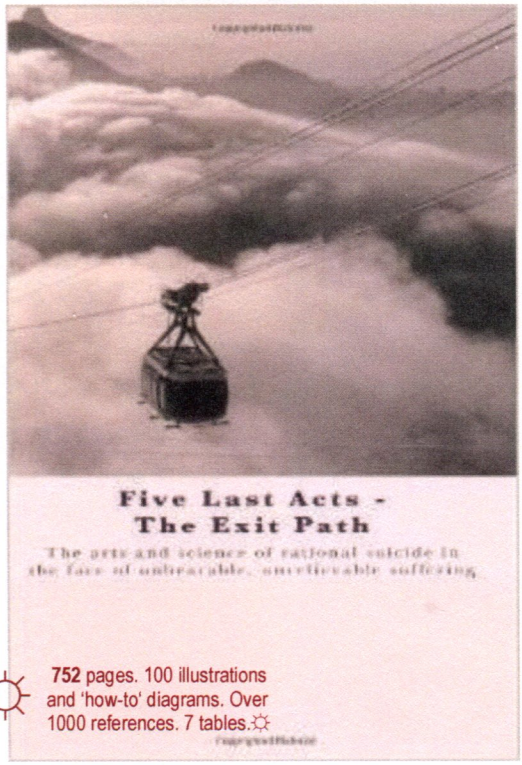
Examining methods of self-deliverance



(I have included some seminar slides for the benefit of those who were unable to be present.)

(Introducing Exit)
The organization is independent and not connected with any Federation or organizations of a similar or same name (such as Exit International). Its methodology is data-led, collating and analyzing data from thousands of studies. Self-deliverance research and publishing is its highest priority, conducted full-time. It is also the explicit reason for the formation of the society (1980) and led to the world's first book on self-deliverance[33].

While there is always great enthusiasm for new methods, Exit believes it is just as important to 'fix' old or existing ideas. Part of the philosophy of its hands-on workshops is that one generally never knows the circumstances that will arise later in life. You may not have the privacy to use helium. You may find you no longer have the ability to swallow many tablets. Familiarization with several methods provides a greater degree of insurance against unknown future circumstances.



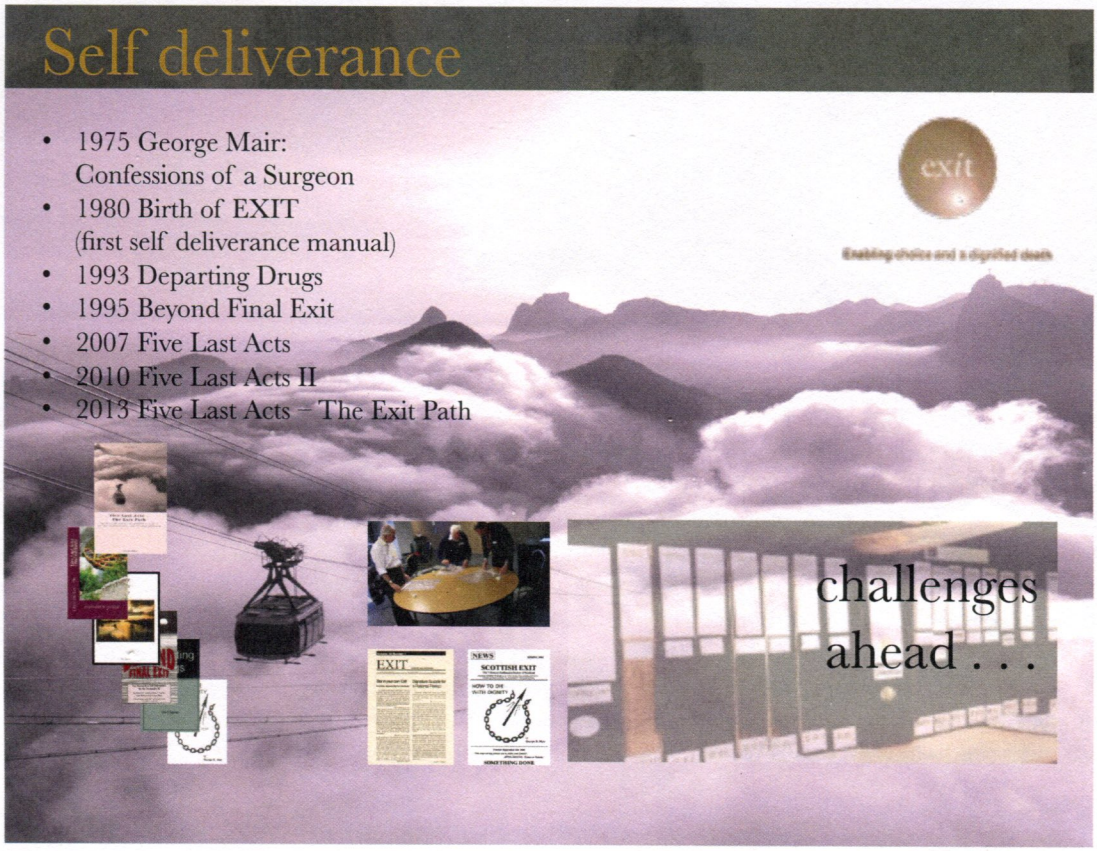
The cover of the book *Five Last Acts – The Exit Path* tells a story. Many years ago, my partner and I had the great good fortune to visit Sugar Loaf Mountain. It was a very special trip indeed. You can imagine the anticipation! But after we had obtained our tickets and climbed in, the cable car rose from the ground only to be immersed in clouds. You could sense the stifled disappointment getting ready to burst. To have come all this way and not be able to see a thing! Then, the cable car rose some more, rose out of the clouds, and into the sunshine.

It is not so different when someone looks at their self-deliverance techniques in the moment of need. The person trusts that it will be perfect. There may be no second chance. But still, there are isolated cases when it is not. For such a person, it is the only case that matters.

This is to highlight the urgency of our task and also the seriousness with which we must address it, the need for

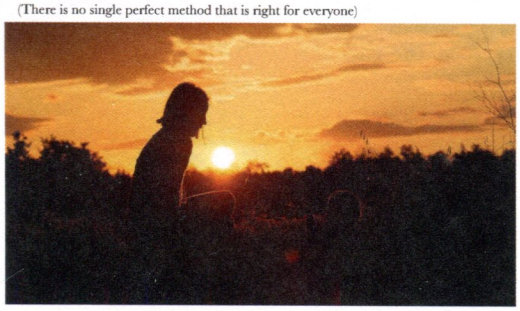
scientific method;[34] and also not constantly to portray ourselves as infallible.

The urgency and critical nature of our common task is as real as a mother clutching her only child and running from a bombed out building. I can only give you a glimpse of how and what we do, from our books, our magazine and our online blog and our workshops. We work with very little funds (which is difficult) and constantly ask ourselves, what benefits will this day bring? To whom? At what cost? Our books rely on facts, with copious citations to argue the validity of our assertions when examining methods of self-deliverance. Our workshops are full-day, participant led, interactive sessions with full dress rehearsals in which members experiment and learn for themselves, in a safe environment, how to make an exit bag, how to unpack and connect a helium tank, what it feels like to adjust the flow, what various tablets look like (or even taste like), how to use ligature compression with everyday objects and even psychological time-lining (moving emotionally to a future time) taking available knowledge to envisage, as realistically as possible, eventualities such as refusing food and liquids. [35] The atmosphere moves quite deliberately from heart-searching seriousness to camaradie or laughter, as we absorb things differently when shared, and according to the associated feelings experienced at the time.


Self deliverance
1975 George Mair: Confessions of a Surgeon
1980 Birth of EXIT (first self deliverance manual)
1993 Departing Drugs
1995 Beyond Final Exit
2007 Five Last Acts
2010 Five Last Acts II
2013 Five Last Acts – The Exit Path
exit
challenges ahead . . .

Learning as we grow

(There is no single perfect method that is right for everyone)

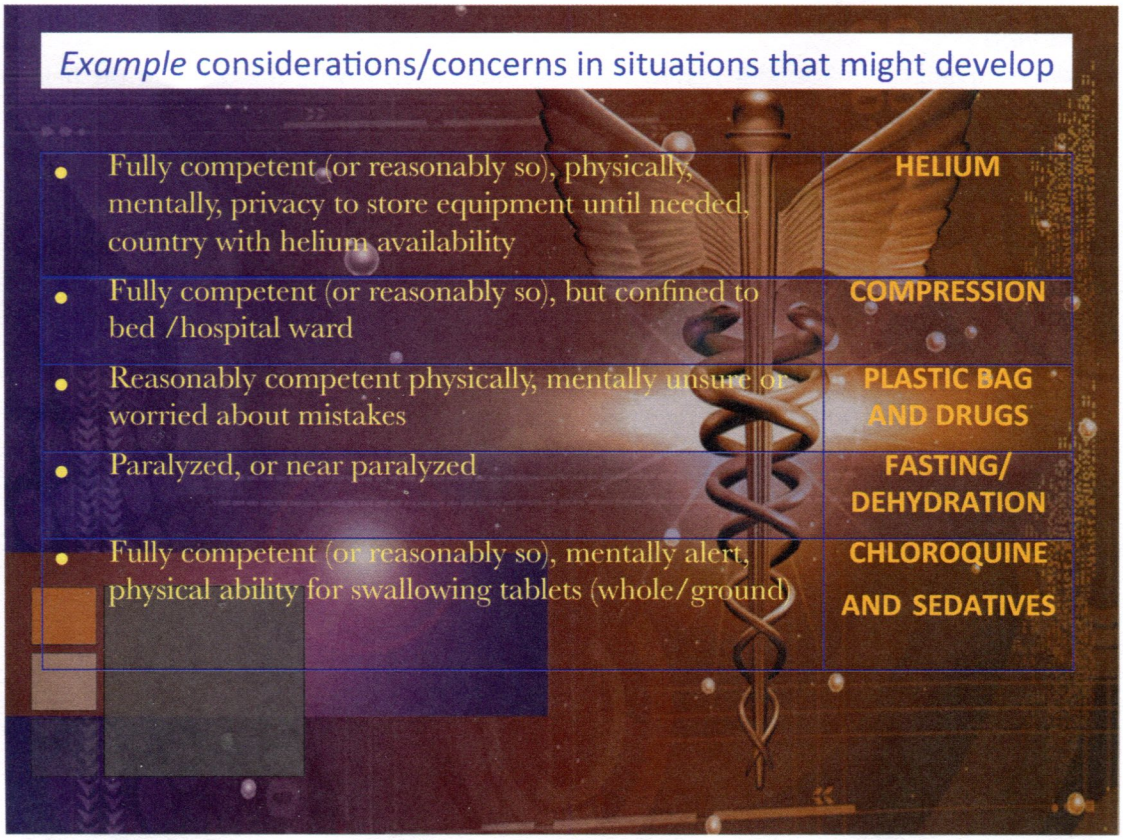


The 28-to-36 page Exit members' magazine contains a mix of academic and light reading with an emphasis on tips and insights on self-deliverance. It is still called *Exit Newsletter* as the material is mostly new! Analysis and comment on news articles (without explicit SD material) is featured on our blog, http://exiteuthanasia.wordpress.com

(The continuing essay only approximates my Chicago seminar, since that was delivered *largely without notes.* It is no way exhaustive[36] – merely touching on some issues that I trust some of you may perhaps find of interest, plus a few extra background notes.)

If helium has such a great success rate, why bother with the others? Helium has a proven reliability with a very low failure rate, but there are factors in favour of, and against, each method. Some of those we can know now, and some depend on future circumstances. Perhaps you find yourself unexpectedly hospitalised, or in a nursing home or some other situation that doesn't allow you the privacy you need for helium. Circumstances can change suddenly with illness, stroke, or accident. Which methods could you manage should you be slightly delirious with pain? (Dress rehearsals will help!) Perhaps you are living in a country where access to helium is difficult. Yet helium is so straightforward, if you have some privacy and mobility and can preferably get things ready in advance, that it is a good option to have.

Similar considerations apply to all the other methods. You can make some choices, but your choices may become limited by circumstances. So the more choices you are familiar with, and ready to use should the need arise, the better insurance you have.


Example considerations/concerns in situations that might develop
Fully competent (or reasonably so), physically, mentally, privacy to store equipment until needed, country with helium availability
HELIUM
Fully competent (or reasonably so), but confined to bed /hospital ward
COMPRESSION
Reasonably competent physically, mentally unsure or worried about mistakes
PLASTIC BAG AND DRUGS
Paralyzed, or near paralyzed
FASTING/ DEHYDRATION
Fully competent (or reasonably so), mentally alert, physical ability for swallowing tablets (whole/ground)
CHLOROQUINE AND SEDATIVES

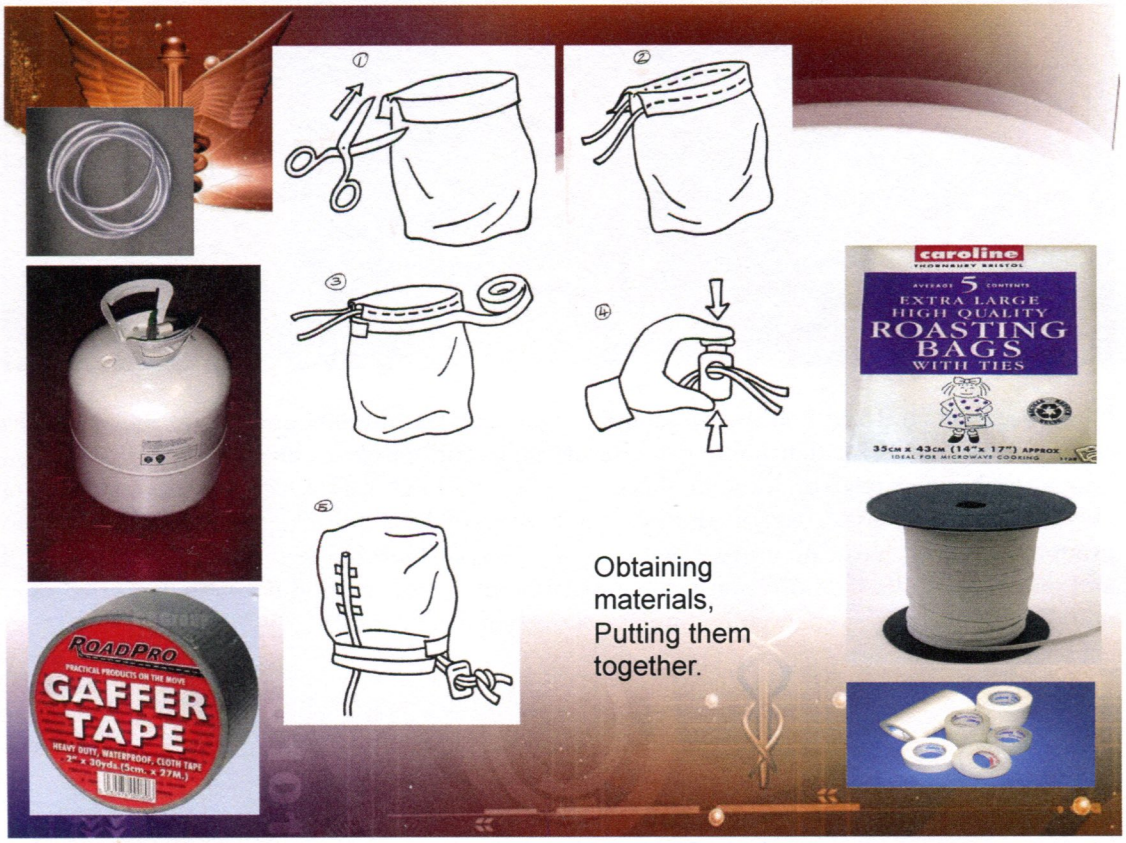
If you become paralysed, refusing food and liquids may be you only option; yet the *preparation and awareness* needed for that method is considerable, and hardly to be undertaken when you find yourself incapacitated. Some methods have an "easy fail' rate. Over-the-counter sleeping pills and a large plastic bag, in the event that you make a mistake, are fairly unlikely to produce enduring harm or distress; whereas the use of chloroquine requires a more careful and precise attitude. Compression is a wonderful emergency method if you can get the hang of it. But although it is remarkably simple, not everyone can.

Helium

(Audience members indicated generally that they were familiar with the basics of the helium method, so this section assumes as much, mostly just adding 'tips.')

Helium should perhaps be the perfect self-deliverance method, but as will become apparent, mostly on account of its perceived complexity, doubts, or over-emphasized cases of very occasional failures, some people increasingly decide it is "not for them." In the workshops, we try to overcome any problems one by one. Making an exit bag (or 'helium hood') is absurdly easy. They are several different methods, but it's really just a big roasting bag with a bit of elastic to stop it slipping off.

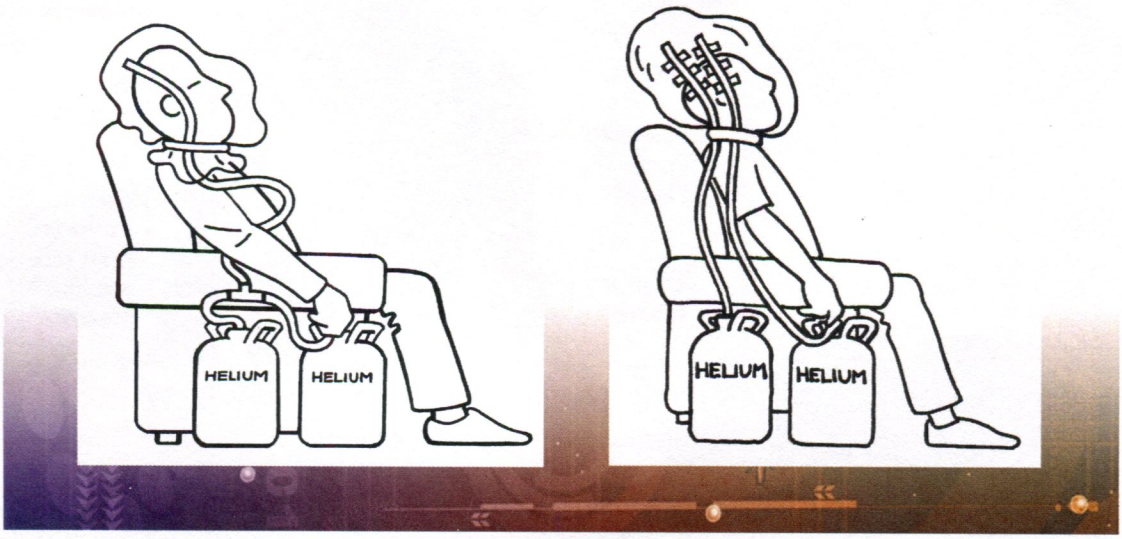
For instance:



Everything that's needed can be obtained from Amazon. You can practice adjusting the closure to see that it is nice and comfy once you've put it together before you connect the tank (although I demonstrate breathing the helium sometimes in workshops I don't recommend this, and certainly not alone).

Other gadgets that come in handy include some bungee cords – those long elasticated cords with a hook on each end. Once you connect the tank you find that it can be annoyingly light which can make it awkward to turn the tap when you are using one hand. So one of the easiest things to do is to pop the tank back in the box, once it's all connected up, then secure the box to the side of your armchair with the bungee cords. That stops it sliding about. If you decide to use two tanks, you have the choice of fiddling about with t-connectors or simply fitting both tubes up inside the hood, as in the next diagram.

HELIUM



You should, of course be familiar with what happens when you switch on a tank of helium, how stiff the tap is and how easy / not easy it is to open and judge the flow (I'll come on to this in a moment).

When we showed this slide at the seminar, my good friend, Russel Ogden asked if I was not worried about the two tubes creating too big an entrance for air to get in. Indeed, perhaps they should be closer together in practice than they are in that diagram. When we have compared the two styles in practicals there seems very little difference except that having two tubes does make the bag a little heavier. But there is another consideration . . .

There are cases, rare but still there, of people who somehow fail using helium. The reasons are not fully understood[37] as it seems almost a scientific impossibility. (You breathe helium, a pleasant experience, pass out, brain ceases to function, you stop breathing and die. One explanation for failure might be panic attack[38], a last minute horror when the bag goes over the head. This should be addressed with dress rehearsals, with the techniques we examine for facing the moment of death (you can download[39] these from the *ExitEuthanasia Blog*) or even a mild tranquilliser.

The other concern is that in a small space, exhaled carbon dioxide causes a hypercapnic response when re-inhaled, rather as it does when you are asleep and the eiderdown falls over your face, partially obstructing your access to fresh air, and you automatically brush it off in your sleep.[40]

Various approaches have been developed to try to address these concerns.

Small bag size and rapid gas flow may minimize the small chance of hypercapnia and any associated panic response

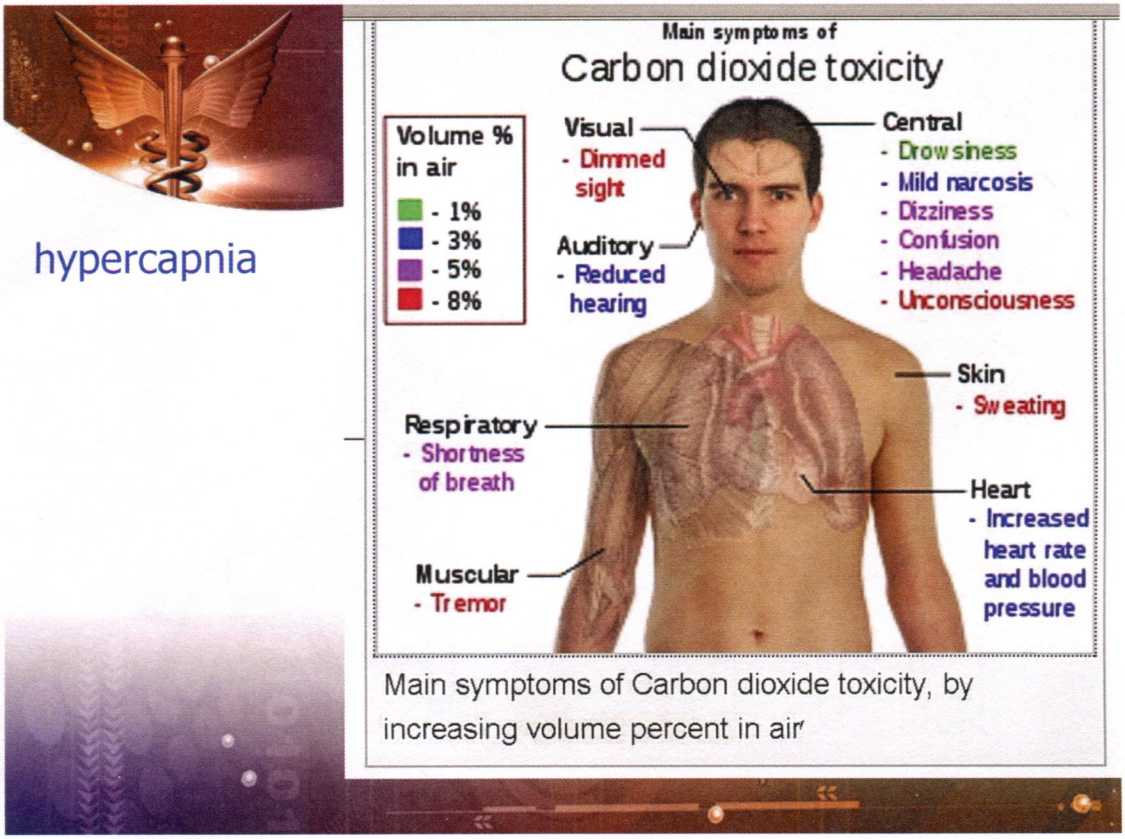


Diagram showing effects of carbon dioxide toxicity[41]

The bag cannot be airtight as the helium has to escape. Additionally, the lighter-than-air helium is pushing any other air (including carbon dioxide) out of the bag as the helium volume pushes downward. My main concern on this point would be if the flow of helium were very slow. Most of the pre-existing air and carbon dioxide can be pushed out first (by scrunching the bag up)[42] then breathing out forcibly before pulling the helium-filled bag over the face. Yet if there is a good flow of helium even this should be unnecessary. You can experiment at leisure by closing an empty exit bag off with a rubber band and turning the gas on, observing how quickly it does indeed fill up with helium. (If you use a gas flow regulator however it takes much longer.)

Many people have gone to great lengths wondering exactly how much to turn the tap on to get the 'right' flow. It seems a devil of a business to adjust it exactly. But then came Swedish tap turners. Using one of these takes away the mystique: the tap can be adjusted as easily as a bath tap and a sensible gas flow is quickly dictated by common sense. We have done this experiment dozens and dozens of times in workshops: switching a tap on and off without a tap turner (passing it round so everyone can try, before the tank is connected up to the hood) and then again but using the tap turner. Looks of puzzlement disappear literally in a puff of gas. It becomes perfectly obvious that you need a good audible flow but nothing so strong as to blow your skirt up from the other side of the room: something that a full tank of helium is perfectly capable of doing. (I've spent many pages on these matters in the book, and must stress that this is only a very quick overview.)

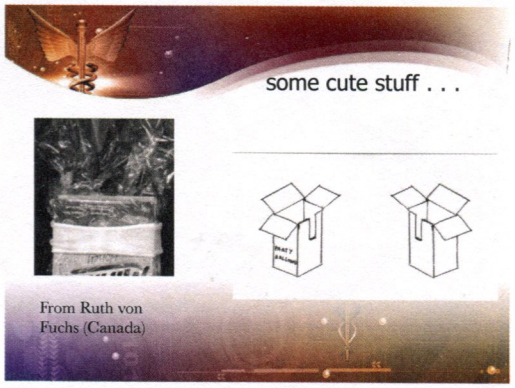
While we are on the subject of gadgets and tricks, here are some slides to show you what I mean. The Swedish tap turner can cost as little as £1 or a couple of dollars. It has prongs that mean it fits to the shape any tap quickly and easily. The loop is an extra you don't see on all models but handy in case you drop it at the last minute. The main point is that it is comfy to hold and gives you great leverage, allowing you to adjust the flow of gas simply and easily.[43] Try it: you will be convinced.

Immediately you experiment with one of these disposable tanks of helium you realise that turning the tap on can result in an unexpectedly sudden rush of gas. It's a small tap, so not that easy to adjust finely under normal circumstances. This leads some people to invest in a flow control valve, which I have mentioned in the other section of this paper. The use of the tap turner though dispels most worries about adjusting the flow.

Here's some other slides you might find interesting. You can assemble two tanks and put them back in the box and even have a matching cutaway if you still want to have a t-connector. Tape the whole lot together with gaffer tape and cover it with a large tablecloth or something, maybe a few books as well or a tray for tea.. That way you can have a ready-to-use kit discretely hidden away from visitors. The other diagram shows you how to make a bag that looks like the old Gladd Bags, with a posh comfort band instead of elastic thread. I made this one in the office but have to thank the wise Ruth von Fuchs[44] for the way of putting it together. You can't easily thread it through a cuff like you can with elastic so she suggests using a cereal box while taping it down.

Another gadget we've used when the exact size of tubing was hard to come by is plumber's silicone tape. A few inches adroitly applied to the helium nozzle and you can make a good fit with tubing that is slightly too large. Generally speaking, and with whatever size of tubing is used, a bit of gaffer tape to make sure it can't slip off doesn't go amiss.

Making a helium hood is a fun exercise and worth practicing. If there is a group of you, you can even have a race. I have many a time witnessed the gaiety at a workshop as several elderly ladies excitedly finish their hoods and try them on for size. It's a bit like a version of the lunar landing!



Ready-assembled and stored in its box, helium can also stay discretely in the boot of the car, ready to be strapped into the passenger seat for use.

This is the way we do it in our workshops

00:48.64
This is the way we do it in our workshops

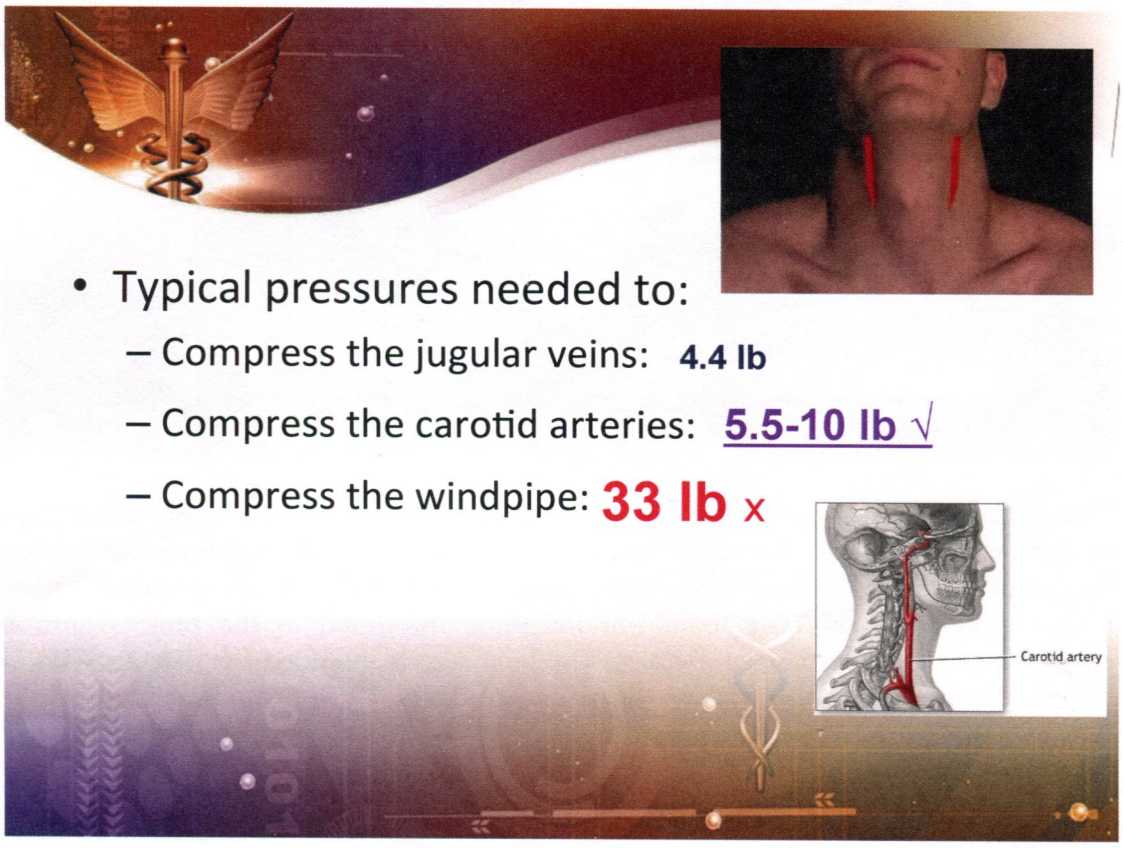
Ligature compression

Ligature compression involves compression of the arteries that supply oxygenated blood to the brain, using a ligature at the neck in such a way as to avoid the discomfort associated with compressing the windpipe. The various techniques[45] to accomplish this are examined in the book, but the principle one and the one described here is that of a tourniquet. The tourniquet must be applied high on the neck to avoid the windpipe, and tightened fairly rapidly to avoid the excessive perfusion that occurs if the veins are compressed before the arteries. (Veins need little pressure to occlude, arteries quite a bit more, and the windpipe much, much, more: if you compress all equally but slowly, veins are compressed as blood continues to flow into the head but cannot flow out, creating a slightly uncomfortable swollen feeling.)

For dress rehearsals, it is sufficient to familiarise oneself with making a suitable knot, inserting a rod of some sort, and tightening it in a few swift turns, not enough to stop circulation in the practice runs, and observe that the rod and tourniquet remain in place. It doesn't 'unwind' as some people imagine it will, but will catch on the chin or shoulder blade. (At this point I am giving a quick overview only. It took minutes to demonstrate in the seminar, but takes many pages to explain satisfactorily.)

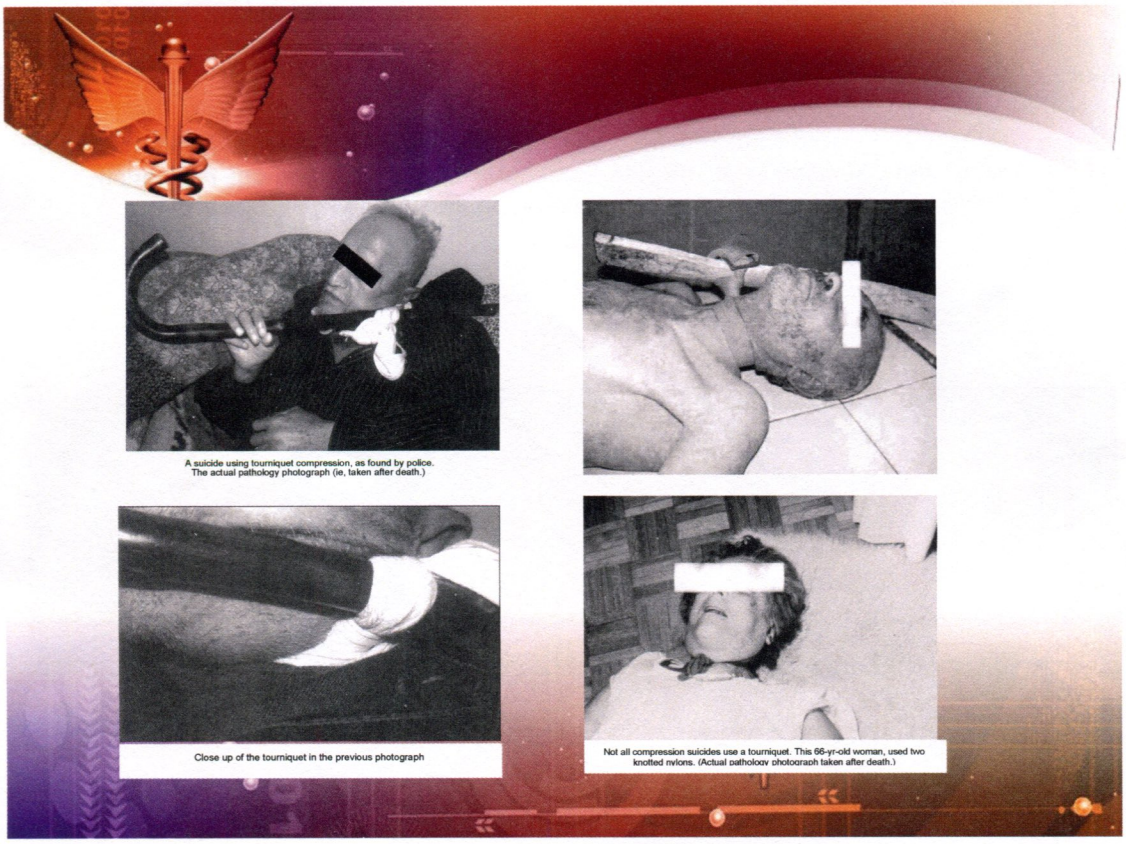
The first medical experiments on compression of the arteries in the neck without discomfort was probably in the early part of the 19th century, where a medic famously experimented on himself, recording the results in minute detail.

> "Fleischmann placed cords round his own neck between hyoid bone and chin, tied them tightly, sometimes at the side, sometimes at the back, without respiration being interfered with, because there was no pressure on the air passages."[46]

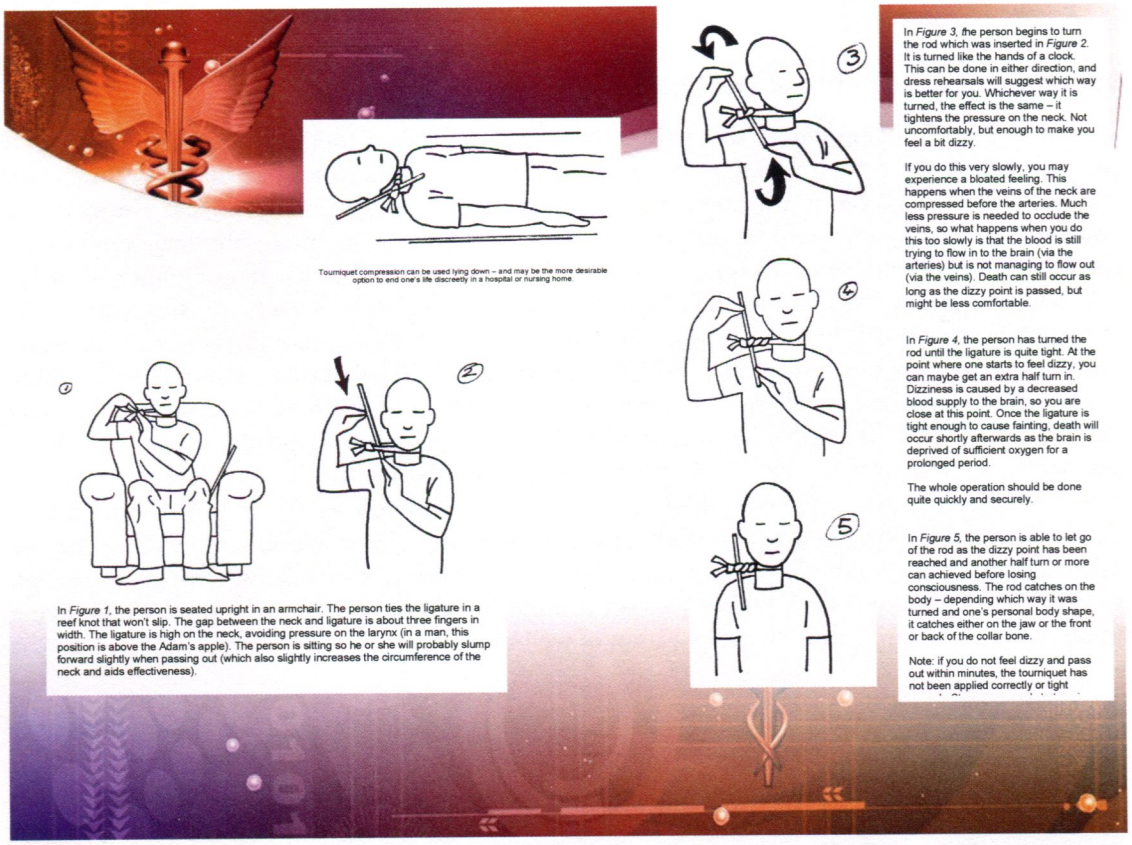

• Typical pressures needed to:
– Compress the jugular veins: 4.4 lb
– Compress the carotid arteries: 5.5-10 lb √
– Compress the windpipe: 33 lb x
Carotid artery

Since then, large numbers of cases and descriptions have found their way into the medical journals. Although primarily discussed in pathology and suicidology, other areas where the mechanism itself is commonly found include the martial arts and sexual deviance (particularly auto-erotic asphyxia). The sensation is akin to fainting (it is in effect artificially induced fainting) and the difference between the judo hold that causes temporary loss of consciousness, forms practiced to achieve a temporary "high," and compression as a means of ending one's own life, is that the pressure remains in place and the arterial blood supply is not resumed.

The rod used for tightening the ligature is a matter of personal preference, though in workshops we find that most people find a shorter rod easier to handle (a longer one gives more leverage). One-inch rufflette, as sold by any haberdasher, makes for a comfortable tourniquet material. The knot should be such that it doesn't slip (e.g. a reef knot), with a space of about three fingers' width between the ligature and the neck if using a small rod such as wooden spoon. Several swift turns produce a 'dizzy point' ('almost' fainting), which indicates partial occlusion of the arteries. A slight increase will complete the process and the person remain unconscious until the brain and breathing stop, death ensuing.


A suicide using tourniquet compression, as found by police.
The actual pathology photograph (ie, taken after death.)
Close up of the tourniquet in the previous photograph
Not all compression suicides use a tourniquet. This 66-yr-old woman, used two knotted nylons. (Actual pathology photograph taken after death.)

You can see from these pathology photos some variations, and the absence of any sign of distress in the faces of the deceased. Various theoretical objections have been thrown about, in spite of quite persuasive statistics from various sources and countries. I have provided a separate hand-out for those interested in the more technical physiological and neurological details. The language is intended for persons with at least some medical background; but worries concerning PVS, or the small alternative blood supply to the brain stem, or the Circle of Willis are, on examination, almost certainly groundless (and mostly depend to temporary rather than fixed compression).

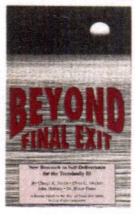

Tourniquet compression can be used lying down – and may be the more desirable option to end one's life discreetly in a hospital or nursing home.
In *Figure 1*, the person is seated upright in an armchair. The person ties the ligature in a reef knot that won't slip. The gap between the neck and ligature is about three fingers in width. The ligature is high on the neck, avoiding pressure on the larynx (in a man, this position is above the Adam's apple). The person is sitting so he or she will probably slump forward slightly when passing out (which also slightly increases the circumference of the neck and aids effectiveness).
In *Figure 3*, the person begins to turn the rod which was inserted in *Figure 2*. It is turned like the hands of a clock. This can be done in either direction, and dress rehearsals will suggest which way is better for you. Whichever way it is turned, the effect is the same – it tightens the pressure on the neck. Not uncomfortably, but enough to make you feel a bit dizzy.
If you do this very slowly, you may experience a bloated feeling. This happens when the veins of the neck are compressed before the arteries. Much less pressure is needed to occlude the veins, so what happens when you do this too slowly is that the blood is still trying to flow in to the brain (via the arteries) but is not managing to flow out (via the veins). Death can still occur as long as the dizzy point is passed, but might be less comfortable.
In *Figure 4*, the person has turned the rod until the ligature is quite tight. At the point where one starts to feel dizzy, you can maybe get an extra half turn in. Dizziness is caused by a decreased blood supply to the brain, so you are close at this point. Once the ligature is tight enough to cause fainting, death will occur shortly afterwards as the brain is deprived of sufficient oxygen for a prolonged period.
The whole operation should be done quite quickly and securely.
In *Figure 5*, the person is able to let go of the rod as the dizzy point has been reached and another half turn or more can achieved before losing consciousness. The rod catches on the body – depending which way it was turned and one's personal body shape, it catches either on the jaw or the front or back of the collar bone.
Note: if you do not feel dizzy and pass out within minutes, the tourniquet has not been applied correctly or tight

There is a small note of caution needed when performing dress rehearsals. The 'dizzy point' needs to be approached with care or you could pass out and not recover! (safer to practice in company: there would be little or no danger of you passed and out and the ligature was removed immediately). For susceptible persons there is also a tiny chance of vagal inhibition. This is when pressure on certain receptors in the carotids can trigger a heart attack.[47] (Vagal inhibition, Circle of Willis and circulation issues, brain haemorrhaging, and destruction of the brain stem with the death of the brain are all covered in very extensive detail in the my book but there is not room to do so here. The current book's recommendations differ from earlier editions slightly in that the precaution of having a plastic bag at the same time as ligature compression has ceased to be very supported by evidence now accumulated, and this is also explained.)

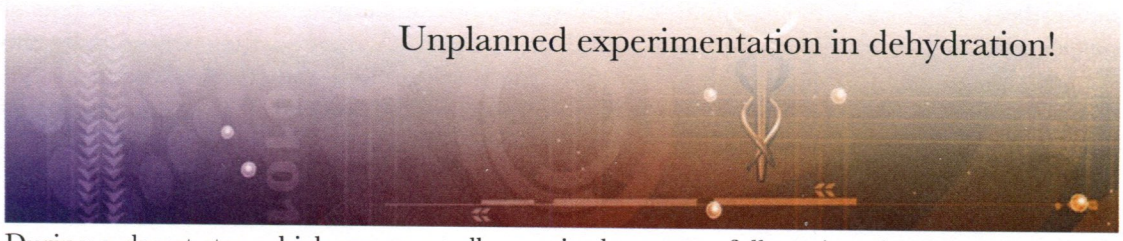
The great advantage of the ligature compression method is that it can be practiced almost anywhere, at any time, and with materials easily to hand that do not arouse suspicion. There is a case in the medical journals of a woman even using it in hospital (at night, under the bedclothes). The disadvantage is that, even in workshops, sometimes as few as 50 per cent of participants will comprehend and feel confident to use it. A method that is essentially the simplest imaginable can be difficult to communicate successfully (some people also report that a 'final' action so close to the head feels more unnerving than one such as helium, at arm's length). Further research is needed on the ways to communicate ligature compression.

Starving one's body of food and liquids

This is popularly being called things like 'voluntary refusal of food and liquids' (although I personally find the terms 'terminal fasting,' or even 'starvation,' a lot less of a mouthful – no pun intended – as long as we then, of course, go on to explain precisely what we mean!) I consider it a complex method, requiring much attention to mental, physical, emotional, medical, nursing and social factors. I wrote what I think was the first major paper on it for self-deliverance in 1995,[48] drawing together data from a wide variety of situations. The remarkable Dutch psychiatrist, Boudewijn Chabot, has expanded our knowledge with some case studies he has performed in the Netherlands, and as I believe he is probably speaking about his work at the conference I will not say a lot about it here (there's a couple of chapters on it in The Exit Path.)[49] People have died well using this method and there have also been relatively recent, horrific cases of persons dying badly in the U.K. after one society recommended it, which maybe highlights both the differences of environment and of communicating. We have a responsibility here: if someone dies screaming after following the advice, or trying to follow the advice, of a right-to-die society, it's obviously not good enough to say, "well you didn't do it correctly;" yet it underlies the desperation both of people living in an illiberal country[50] and the desperation of well-meaning societies to help.



1995-now



During a desert stay which unexpectedly required very carefully rationed water, some of the symptoms, which included extreme thirst sensation (after tiny sips of water) giving way to indifference and euphoria (as the thirst sensation dissipated) mimicked to an extent those symptoms observed by Chabot and others in cases of voluntary terminal dehydration.[51]

A nebuliser can provide a fine mist

- If you will be quadriplegic or otherwise severely paralysed: especially consider the fasting (starvation-dehydration) method.
- Prepare well in advance. Anticipate possible complications.
- Have a physical check-up and consultation.
- Prepare. Prepare. Prepare.
- Arrange sufficient nursing/medical care to alleviate symptoms.
- Make sure that you, and your loved ones, have stored up plenty of will-power.

A question of safe dissemination

Starving / dehydration is **not** an 'easy' method to follow. . . Mistakes are easy to make.

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Retired GPs advise terminally ill on suicide by starvation

Retired doctors are helping patients starve and dehydrate themselves to death to circumvent the legal ban on medically assisted dying.

By Simon Johnson
2:54PM GMT 08 Mar 2009

Comment

The former GPs have advised those who are terminally ill or suffer from a degenerative disease that they can end their lives by refusing food and drink.

They admit the process is "horrific", with one woman starving herself for 25 days before she died, but said there is no alternative in [redacted] as long as euthanasia remains illegal.

The doctors are members of the campaign group [redacted] which lobbies for the introduction of assisted dying and gives practical advice on suicide.

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Health News

(the above newspaper report was among the less lurid reports. It was picked up by patient rights groups, at least of which issued a leaflet warning about refusal of food and liquids.

Hydrogen sulphide

This 'detergent suicide' (achieved by mixing household chemicals to form a deadly gas) is rapidly becoming the favourite method of people who seem suicidal without the kind of rationality that characterises our movement. I have received many angry emails from people advocating the method and claiming helium is 'too complicated' or 'can't be relied on.' It is certainly lethal, but to be painlessly so requires a 'knock-down effect' – a rapid high concentration of gas that causes unconsciousness within two or three breaths (death otherwise can be expected to be very unpleasant). Household chemicals do not have the same requirements of precise and consistent composition that, say, pharmaceuticals do. Variations causing a lessening either of the speed with which gas is emitted or the quantity would be a big problem. The method has largely been shunned (except for passing analysis) by the RTD movement, due to the dangers likely for bystanders or persons finding the body; but these dangers could theoretically be overcome. I believe Dr Jerry Metz has also done some work on it as a method but unfortunately he had to leave the Conference before the NuTech sessions.

Hydrogen sulphide (H_2S)

Exposure	Parts Per Million (ppm)	Physical Effect
Low Level	< 40 ppm's for less than 15 minutes	Eye and mucous membrane irritation
Moderate Level	> 20 ppm	Pulmonary membrane irritation
High Level	50 – 400 ppm	Cough, dyspnea, cyanosis and confusion
Severe – High	>500	Fatal systemic toxicity

Hydrogen sulphide toxicity table taken from the Hampden County Sheriff's Department manual, "Chemical & Detergent Suicides."

Firearms

A last minute email from Faye Girsh persuaded me, given that several members had also asked about it, to probe a little deeper into the question of guns and dignified death. To most people, it sounds abhorrent: violent and messy. Yet we do have plenty of instances of undeniably quite dignified death. Only weeks before, a couple had carefully ended their lives together, phoning the police just before they pulled the trigger. In America, where more people overall die by suicide with guns than by firearms homicide, there are moving cases such as the rancher who quietly went into the woods one day. Or Ernest Hemingway, for whom firearms probably suited his lifestyle persona (we included a mention under a magazine article entitled "signature suicides.") There is very little written in self-deliverance manuals on them, even ours. Mostly there is the standard advice, "use a high calibre gun, place it in the mouth pointing upwards;" or something along those lines. I pointed out to Faye that proper research takes weeks, not hours or even days. Yet it seemed worth doing some preliminary work (which duly appeared in the magazine). A couple of salient facts come to mind. One, not surprisingly, is that most successfully dignified deaths using guns seem to involve people who are very familiar with their use. The other, slightly more surprising, is that over a certain calibre and velocity, even an expert has some difficulty controlling the recoil. This is important since uncontrolled recoil as the gun fires can alter the trajectory, sometimes with very serious, disfiguring yet not fatal, results.[52]

(Various other fringe methods are dealt with in the book. Methods involving lethal drugs alone require considerable technical attention in my opinion so will not be addressed here. I have also replied in the book to criticisms of my analysis of the role of benzodiazepines when used with chloroquine although it is fairly academic, as if you ingest enough of both you die anyway.)

Plastic bags and drugs

This method fell into disrepute after a number of failed episodes and the rise in popularity of helium, but at Exit we analysed the causes of failure, uncovering new data, making it a fairly good method of rational suicide.

In the early '90s, comparing notes with European colleagues, I was puzzled by the recurrence, frequent enough to be worrying, of certain accounts that had features in common. The person would take enough sleeping tablets to send them to sleep and then quickly putting a bag over their head after taking the pills, tied or elasticated around the neck. They would fully expect to fall asleep and then die of anoxia. Yet in some cases they would either wake up many hours later and take the bag off, or else find they had *torn the bag off in their sleep.*

We racked our brains over this for a while. It was around the time I was researching the *Departing Drugs* booklet and wanted to explore all possibilities. The first part of the mystery was solved by sheer accident. I had discussed the predicament socially with several of the professors in law and medicine at Glasgow University (where I had also been researching living wills). By total chance, the conversation was overheard by a friend of a friend, a professor in the physics department. "But it's obvious!" he exclaimed. We all looked at him in bewilderment. "Oxygen molecules are tiny," he continued. "They will pass through the plastic and provide enough oxygen to keep the person just about alive." This was news to us. Gas molecules passing through solid matter? But indeed it is fairly basic physics (as we discovered after a rapid rake through the relevant reference books in the department). But we also discovered that it varies with the type of plastic used in that particular bag. Some types of plastic bags are more oxygen-permeable than others.[53] Unfortunately although bags are supposed to be marked to show what material they are made of, frequently the mark seems to be omitted. Finding "the right type of bag" would not be so straightforward.

Then it transpired that the sort of bags we were looking at were *mostly* made out of the less permeable plastic, which might explain some of the inconsistency. Suspecting there was more to it, we started looking into the drugs question.[54] The problem of someone pulling or tearing a bag off on their sleep was likely a result of hypercapnic response (the exhaled carbon dioxide effect, mentioned earlier). As the levels of carbon dioxide in the bag rise, and the levels of oxygen decrease (the two also have a synergistic effect), the tendency to movement increases. They would be asleep, but not so deeply that they couldn't thrash about a bit in their sleep. The exact mechanism is rather involved[55], but I am sure we all recognise, maybe from early flat-sharing days perhaps, the difference between someone who is just 'asleep' and someone who has fallen asleep after a heavy night's drinking, maybe even on the floor, and doesn't wake up easily even with a good shake. One person is just sleeping and the other, as we might say in British slang, is 'paralytic.'

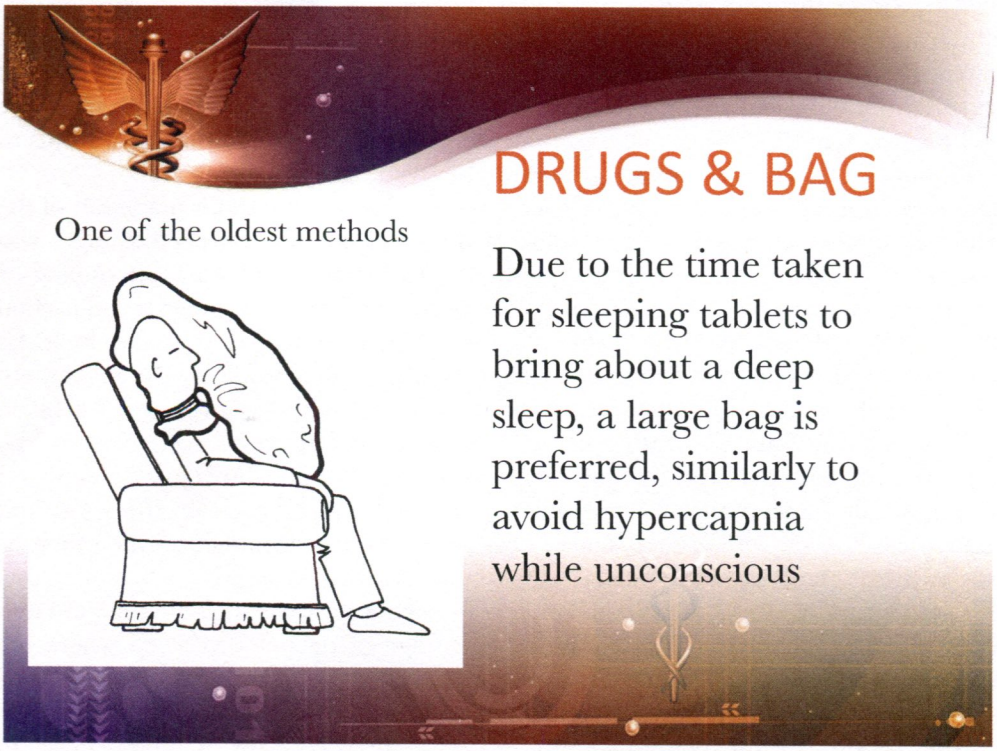
This made us think about the gradual effect of sleeping drugs as they are ingested and then enter the system. What we want to happen is a stage of deep REM sleep where the muscles are paralysed;[56] and for it to occur before the oxygen levels in the bag get so low and the carbon dioxide levels get so high that motor action in the arms is triggered, tearing the bag off. Most people would be sufficiently sedated anyway with a good dose of benzodiazepines or similar (we recommend 10 times the amount required for eight hours daytime sleep, which varies from individual to individual); but a few might have more sensitive sleep patterns.

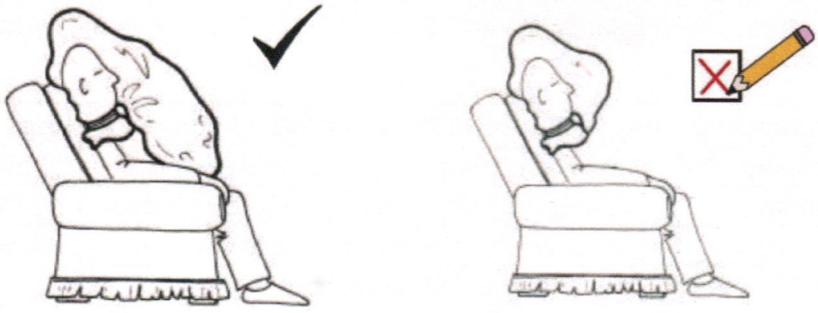
Understanding sleep architecture – the natural stages of sleep				
N1	Light sleep	Slow brain waves	theta waves	5 mins
N2	Transition	Rhythmic brain waves	sleep spindles	20 mins
N3	Deep sleep	Very slow brain waves	delta waves	30mins
R	Deep REM sleep	(skeletal muscle paralysis)		

above: so-called "sleep architecture" [57]

What was clear was that, for whatever reason, there are different levels of sleep and muscular incapacity. In a nutshell, the drugs need time to put you in a deep, immobilised sleep before the lack of oxygen in the bag causes your brain to die. For that you needed quite a big bag. With my co-author, I convened a meeting of an international drugs consensus working party. We sat around the table at Exit considering the final draft. We had done some calculations on how long the air would last and how quickly we thought the drugs would take to bring about the state of deep sleep. At this point, Colin, in the immaculately precise, received pronunciation of his English heritage, chimed in, "Carry on, chaps. While we are discussing, I'm going to place this bag over my head and, if someone can watch for when my fingertips start turning blue, we will have a pretty good idea of when anoxia is occurring!" Sure enough, at about the 50 minute mark, his fingertips had a slight bluish hue (one of the first signs of anoxia). We had verified at least a crucial part of our experiment.[58] There were no more reports (as far as I can remember) of drugs+bag failures using our revised information.

When used with sleeping drugs, the opposite of helium is true: to avoid hypercapnic response: the bag should ideally be so large that the body is too deeply sedated by the time CO_2 levels would otherwise trigger a reaction (5%).

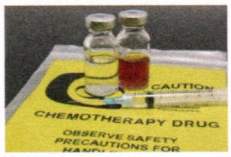

DRUGS & BAG
One of the oldest methods
Due to the time taken for sleeping tablets to bring about a deep sleep, a large bag is preferred, similarly to avoid hypercapnia while unconscious



New ideas and suggestions for further research

Solving puzzles
ANTI-EMETICS

1st question might be: What do the scenarios on the left all have in common?



*It is a danger in **assisted suicide** and an even **bigger** danger in **self-deliverance**. Yet . . .*

UNLIKE THE ASSISTED SUICIDE PROGRAM THEY ARE DOING SOMETHING.

Standard anti-emetics prescriptions don't always work. More than 1 in 17 patients prescribed lethal drugs in Oregon suffered complications, almost all of which involved vomiting.[59] Unlike other critical areas of medicine, there seems to be no ongoing research into improving anti-emetic prescribing. The official guidance in Oregon if you vomit the medication is to "call a doctor." **Not exactly an option for a person using self-deliverance.**

Other fields are showing promising results using combination anti-emetics in what is a complex area (there are many different factors involved. It is such a serious problem that I've included an introductory chapter, but some field work is sorely needed. There is less of a problem where a doctor is on hand (in Dutch euthanasia) or can be called (in Switzerland): but many persons still use drugs and drug combinations for self-deliverance. Until more work can establish the safest and most accessible options, metoclopramide or domperidone are likely to remain the favoured ones. Each have advantages and disadvantages

Exit has summarised some of the related findings so far, and also some of the many different factors involved with the different anti-emetics (see hand-out – if you were not able to get a copy it will be attached to this document or as a separate download).

COMPRESSION

Can we solve the communication problem so more people are able to make use of this safe and simple method? If you saw the demonstration at the seminar there is also a chapter available on how we present and look at communication issues in the workshops. We have handled the technical questions and objections (in great detail!). Can anyone suggest more ways forward perhaps on the teaching and communication?

HELIUM

We still have largely unexplained (if rare) failures. What are your thoughts? Does the bag+drugs section here give us any clues? Helium atoms are less than 1 Angstrom in diameter, where as nitrogen and oxygen, the 2 main gaseous components of air, are approximately 10 Angstroms (1 nanometer) in diameter. Is gas escaping from cylinders before they are used? (I have experimented with a pressure gauge but don't personally find this a conclusive method of judging the amount of helium left. Switching it quickly on and off seems to give a good idea). But gas tanks being half empty hasn't adequately accounted for all the factors noted in credible accounts from members of different societies. More research is needed.

Other avenues

H_2S

I am interested to see if the objections on this apparently abhorrent method can be overcome.

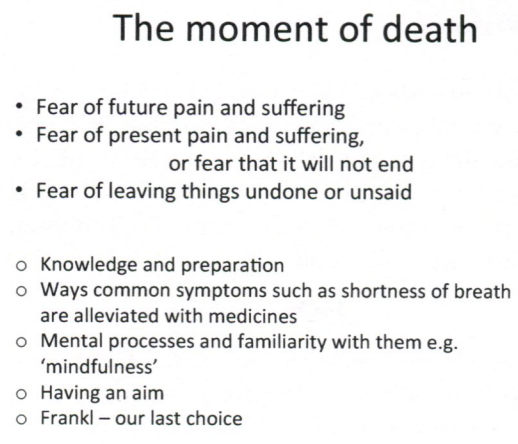
FIREARMS

I don't have our magazine article available as a pdf just yet. It would be extremely helpful if there is anyone who is familiar with firearms, practically and technically, and also able to resource and have a go at the large amount of data that needs to be analysed?

The moment of death

Response to my article on this was overwhelmingly positive. Even many persons involved in our movement and quite capable when it comes to arranging their own self-deliverance, feel considerable queasiness or fear when faced either with the inevitable prospect (as for instance when a terminal diagnosis has been presented) whether anticipating self-deliverance or not, in the final few minutes as death approaches. Finding good peer-reviewed data (among a mountain of well-meaning hocus-pocus) seemed to be worthwhile. Our communication of self-deliverance techniques is, after all, just a part of the puzzle of taking away the fear of dying badly. State of mind of mind also has to be addressed in many if not all cases.

On the way to the conference I was reading Viktor Frankl's beautiful short book on *Man's Search for Meaning*. [60] During his time in Nazi concentration camps, Frankl (a psychiatrist and philosopher) noticed differences in the mental attitude of those that coped best and survived longest. He called it the final choice: *one's attitude of mind*. The ability then to find joy in the most terrifying of circumstances and yet how 'meaning' is individual to everyone, at each moment. Death for each us will be special, individual and meaningful. In some of the accounts we have seen of a member's last moments, there is a certain magic there, an inspiration that will live on.

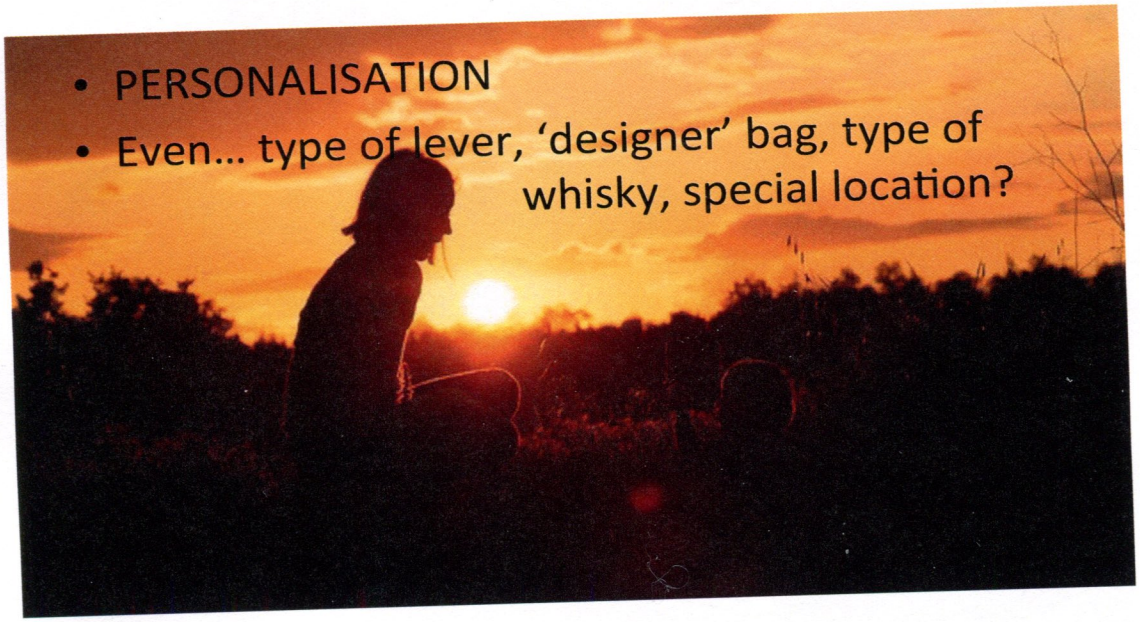

The moment of death
• Fear of future pain and suffering
• Fear of present pain and suffering,
or fear that it will not end
• Fear of leaving things undone or unsaid
o Knowledge and preparation
o Ways common symptoms such as shortness of breath are alleviated with medicines
o Mental processes and familiarity with them e.g. 'mindfulness'
o Having an aim
o Frankl – our last choice

Dying is perhaps an art as well as a science.
More than just the method you choose; or even that chooses you.

three steps to a good death

- Visualise it. See it in your mind's eye and feel the emotion of having everything in order.
- Focus on the end goal. Think of nothing else while you work out the details. Do the dress rehearsals until you know without a shadow of a doubt that you are completely capable and confident and will be at ease with it in the future.
- Be persistent. Work out details in practice as well as in your mind's eye. Revise them annually.

Ars moriendi



Dying is usually a process that is as active as it is passive. It is much a doing as an undoing. It involves choices and attitudes as well as letting go. It's a final dance with elaborate steps, and we usually have to improvise.

Gabrielle Roth

In accordance with British law, Exit does not engage in one-to-one advice on suicide methods. For academic questions, enquiries, discussion, collaboration or responses, comments or notifying us of any errors, please make reference to the appropriate section in "Five Last Acts – The Exit Path" if possible when corresponding. Reach us on exit@euthanasia.cc or Skype or Facetime

Hand-outs (1) anti-emetics

ANTI-EMETICS

There is not a standard pill that can stop you vomiting; but very little has been written on assessing the differences between various anti-emetics for self-deliverance. Vomiting is believed to be controlled by two different brain centres: the vomiting centre and the chemoreceptor trigger zone. Both are located in the medulla oblongata, which is located in the lower half of the brainstem and controls involuntary functions such as breathing, digestion and heart rate. The vomiting centre adjoins several structures involved in the coordination of vomiting, including salivary, vasomotor and respiratory centres, and cranial nerves.[1] The centres consist of intertwined neural networks. For convenience, let's take three main categories of anti-emetics: dopamine blockers, antihistamines and 5HT3-receptor agonists. These are not exhaustive and are chosen for their potential relevance to self-deliverance. They provide a general picture only but by expanding our knowledge we can become more secure in our choice of an anti-emetic.

Dopamine blockers

Dopamine blockers (also called 'dopamine antagonists') include domperidone[2], metoclopramide[3] and prochlorperazine. They are therapeutically used to treat nausea resulting from opioids, chemotherapy drugs and general anaesthetics. They are not always perfect (no anti-emetic is 100%[4]), but generally seem the best bet. Unlike therapeutic drug testing, there is little or no good data available for anti-emetics in self-deliverance, or even assisted suicide. The preferred drug in assisted suicide today is usually metoclopramide, but even that has seen a small percentage (fortunately very small) of failures. A similar drug, domperidone, is currently available over-the-counter in the UK and generally recommended for self-deliverance. A third drug is a phenothiazine called prochlorperazine. Metoclopramide and domperidone help to empty the stomach and so relieve feelings of sickness. It is also known under the brand names Reglan (USA), Maxolon (Australia & UK), Plasil (Brazil) and so on.

Domperidone equally has many brand names, chiefly Motilium. It is not generally approved for prescription in the U.S.A. But domperidone tablets are available over-the-counter in the UK. It is less likely to cause sedation than metoclopramide and is sometimes available as a suppository. Domperidone does not readily cross the blood-brain barrier and therefore has an advantage over metoclopramide of being less likely to cause central nervous system effects.[5]

Prochlorperazine is sometimes known as Compazine or Stemzine and acts on the vomiting centre in the brain. Chlorpromazine is an older generation antipsychotic, another phenothiazine with anti-emetic properties, but it is also highly sedating. Prochlorperazine, metoclopramide and chlorpromazine are currently prescription only in the UK.

Antihistamines

The next category are antihistamines, also referred to as 'histamine receptor antagonists.' With the availability of more suitable drugs for self-deliverance, these weaker anti-emetics are less recommended. In nausea, they are mostly for travel sickness, morning sickness in pregnancy, or combating opioid nausea. Antihistamines include dimenhydrinate (Dramamine), promethazine (Phenergan) and diphenhydramine (Benadryl). Their

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1 Rousseau P, Antiemetic therapy in adults with terminal disease: A brief review, Am J Hosp Palliat Care, 1995;12(1):13-18 provides a good overview and a fuller technical overview than seems appropriate here.
See also Donnerer J (ed), Antiemetic Therapy, Karger 2003 for more information on anti-emetics generally (this is a technical manual).

2 Barone J, Domperidone: a peripherally acting dopamine2-receptor antagonist, Ann Pharmacother 1999;33(4):429-40.

3 Metoclopramide . . . works on the stomach and proximal small bowel, but has little effect on colonic motility. In addition to its prokinetic effects, metoclopramide also antagonizes D2+ receptors in the chemoreceptor trigger zone. Glare P, Miller P, Nikolova T, Tickoo R, Treating nausea and vomiting in palliative care: a review, Clin Interv Aging. 2011; 6: 243–259.
Also "Metoclopramide and domperidone antagonise dopamine receptors in the chemoreceptor trigger zone which are involved in the vomiting reflex. In addition they are both prokinetic anti-emetics, as they increase the rate of gastric emptying and peristalsis. They also decrease the sensitivity of receptors in the pharynx and upper gut to noxious stimuli." Butler M, Courtenay M, Anti-emetics, nursingtimes.net 98(49) http://www.nursingtimes.net/anti-emetics/205739.article based on Courtney M, Butler M, Essential Nurse Prescribing, Greenwich Medical Media 2002. Accessed 4 Feb 2013.

4 Finkel R, Cubeddu L, Clark M, Pharmacology 4th ed.Lippincott Williams & Wilkins 2009:336-338, gives some averages on effectiveness against vomiting.

5 Butler M, Courtenay M, Anti-emetics, nursingtimes.net 98(49) http://www.nursingtimes.net/anti-emetics/205739.article based on Courtney M, Butler M, Essential Nurse Prescribing, Greenwich Medical Media 2002. Accessed 4 Feb 2013.

primary uses against nausea, apart from motion sickness, include morning sickness in pregnancy, and sometimes opioid sickness. They are considered less suitable for self-deliverance today than when earlier books were written. Mostly consigned to earlier self-deliverance manuals, should antihistamines be written off completely? And, if they were completely useless – as some authors now claim – then why was this not noticed for so many years? The precise action of most anti-emetics is not fully understood At least one trial found that, in a number of cases, a placebo worked just as well as an anti-emetic drug. The assisted suicide facility Dignitas in Switzerland was also quoted as formerly using antihistamines and apparently found they worked (although Dignitas has now switched to metoclopramide.) A considerable number of drug-overdose assisted suicides have been completed with promethazine or without any anti-emetic at all.

If we analyse the actions of the different types of anti-emetics, we see that many have a cross-over between one category and another. Promethazine, for instance, has a high affinity as a histamine agonist (which relates to motion sickness), a moderate affinity as an acetylcholine agonist, and a low affinity (rather than no known affinity) as dopamine agonist.[6] So it is not surprising that some antihistamines have found to be at least slightly useful, rather than 'completely useless.'

5HT3-receptor agonists

The final category is 5HT3-receptor agonists, the best known of which is probably ondansetron (brand names include Zofran, Ondemet, and Demorem). These work by blocking the chemical called serotonin (5HT) which acts on receptors in the gut and brain called 5HT3 receptors. They may also have some anti-anxiety properties.[7] They are mostly prescribed for nausea following chemotherapy. As an example of crossover, metoclopramide is both a dopamine-blocker and yet also has 5HT3-receptor agonist effects.

Side-effects and test-runs

Although there are very few side-effects with domperidone, a person might want to experiment first if using other drugs such as metoclopramide (Experimenting using a therapeutic dose). This is especially recommended if you are thinking of beginning the anti-emetics 24 or 48hrs beforehand, as some people do. Although side-effects of metoclopramide are not usually very serious, they could include restlessness, drowsiness, dizziness, fatigue or depression. Don't leave it till the last minute to see how your anti-emetic might affect you in the hours leading up to a self-deliverance![8]

Other considerations. In looking at the pharmokinetics of these drugs, such things as the speed of action are maybe worth passing consideration:

The *onset of action* for domperidone is half an hour.
The *onset of action* for metoclopramide is from ½hr to an hour.

The time to *maximum blood concentration*
for domperidone is half an hour;
for metoclopramide, less than 1 hour
for prochlorperazine, 1½ to 5 hours
for promethazine, 2 to 3 hours
for ondansetron, ½hr to 2 hours
(for chlorpromazine, 2 to 4 hours)

The *duration of action* is estimated at
for domperidone, 8 to 16 hours
for metoclopramide, 1 to 2 hours
for promethazine, 4 to 12 hours
(for chlorpromazine, less than 24 hours)

The *elimination half-lives*[1] are
for domperidone, 7½ to 16 hours
for metoclopramide, 4 to 6 hours
for prochlorperazine, 6.8 to 9 hours
for promethazine, 10 to 14 hours
for ondansetron, 2½ to 5.4 hours
(for chlorpromazine, 8 to 35 hours)

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6 Glare P, Miller P, Nikolova T, Tickoo R, Treating nausea and vomiting in palliative care: a review, Clin Interv Aging. 2011; 6: 243–259. This well-supported paper gives an extensive comparison of various anti-emetics and diagrams showing the different paths of action.

7 Supra, Rousseau, at p.17.

8 Metoclopramide can increase so-called 'extra-pyramidal' effects of phenothiazines (eg prochlorperazine) so the two should not be taken together. Rogers H, Spector R, Trounce J, A Textbook of Clinical Pharmacology, Hodder & Stoughton 1981;530-531.

Anti-emetics and other drugs of self-deliverance

There is a possibility of interaction between 5HT3-receptor agonist ondansetron and chloroquine. The combination should be avoided until more is known.[9] Amitriptyline[10] may have a small anti-emetic effect, as may benzodiazepines though this due to their calming properties. Chloroquine is known to cause nausea in some persons even in therapeutic doses. Combination anti-emetics might offer reduced problems in self-deliverance and further research is required.[11]

Summary

Overall, domperidone (Motilium) seems a good choice. It has few side-effects and is fairly easily available. It can be used alone or in combination with ondansetron or with prochlorperazine. Ondanestron combined with metoclopramide has been used with good effect. More research could be beneficial. Metoclopramide is also favoured, and a first drug of choice in many medical situations for nausea. One combination to be avoided would be the prokinetic drug metoclopramide with an antihistamine such as promethazine, as the latter blocks the effects of the former.[12] Finally, if you are experiencing a terminal or very severe condition, it is not improbable that you will have cause to ask your doctor for anti-emetics.

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9 Thompson A, Lummis S, Antimalarial drugs inhibit human 5-HT3 and GABAA but not GABAC receptors, Br J Pharmacol 2008;153(8):1686–1696.

10 Bouras E, Talley N, Camilleri M et al, Effects of amitriptyline on gastric sensorimotor function and postprandial symptoms in healthy individuals: a randomized, double-blind, placebo-controlled trial, Am J Gastroenterol. 2008 ;103(8):2043-50.

11 Bakowski M, Advances in anti-emetic therapy, Cancer Treat Rev 1984;11(3):327-56. " ... the use of combinations of anti-emetics with differing sites of action and non-overlapping toxicities, may lead to further improvements in efficacy."

12 Glare P, Miller P, Nikolova T, Tickoo R, Treating nausea and vomiting in palliative care: a review, Clin Interv Aging. 2011; 6: 243–259. "Prokinetic agents stimulate the motility of the upper gastrointestinal tract by four potential mechanisms: activation of 5HT4 receptors, releasing acetylcholine from enteric neurons to stimulate the cholinergic system in the gut wall; blockade of 5HT3 receptors; activation of motilin receptors; or releasing the dopaminergic "brake" on gastric emptying. . . . These prokinetic effects are blocked by antimuscarinic agents, including antihistamine antiemetics. Therefore, it makes no sense to prescribe a prokinetic and an antimuscarinic agent together."

Hand outs (2) compression

Compression is a simple method of self-deliverance that relies on no complicated equipment and does not require drugs. The main veins and arteries of the neck are compressed in such a manner that pressure remains after the person has fainted. Fainting, and death, is a result of lack of oxygenated blood to the brain. It is very quick – fainting occurring within a minute and death following within a few minutes. (In rare cases, death may be accelerated by cardiac arrest after loss of consciousness.) One of the main methods of achieving compression is to use a tourniquet around the neck, carefully positioned so it does not obstruct breathing. Another method is to use continuous looping, and a third is the introduction of mechanical devices. Some momentary discomfort is possible, but brief, and can be minimized with careful forethought. Material can be planned for, or found at short notice. Compression can be used in situations of confinement, such as a hospital stay, or other emergency situations where there is no possibility of using helium or drugs.

Death results from one of three causes:[13]
i) Pressure on the carotid arteries results in loss of consciousness and asphyxia as the brain is denied oxygenated blood.
ii) Pressure on the jugular veins produces 'stagnant hypoxia' or massive reduction in the circulation of the blood – rather like a traffic jam. As blood is prevented from flowing away from the head, the pressure prevents fresh blood from flowing in (similar result as (i) above).

iii) Cardiac arrest due to the so-named 'carotid sinus reflex.' This is less likely than either of the above causes. Pressure is required for at least three to four minutes to produce cardiac arrest – occurring after loss of consciousness.

In all three processes, breathing continues normally until death. The term 'strangulation' in this context does not mean a throttling that interferes with breathing – something very unpleasant. It means a 'strangling' or cutting off of the *blood supply* to the brain. The pressure needed to strangle the windpipe is much greater and not needed for self-deliverance.

Concerns over the possible survival of the brain stem (which have occasionally been documented in rare non-suicidal compression cases involving healthy young subjects) have sometimes prompted suggestions for the use of a plastic bag in conjunction with this method. A small bag, such as that described for helium (a large roasting bag) is suitable. No other preparation is needed, and such a bag is small enough to be folded discreetly or even used to hold toiletries and so avoid suspicion. The only other implements are material with which to make a tourniquet and some sort of rod with which to tighten it. Such things can be found impromptu or kept with one at all times. Careful examination of the process, together with statistical and neurological evidence, suggests however that this added precaution is unnecessary.

Probably the most recent case at the time of going to print involved the use of a dressing gown cord. [14]
One of the first cases in print is reported in the New York Times on 26 November 1879. An elderly man had tied a red silk handkerchief around his neck and then used an eighteen-inch piece of broom-handle to tighten the tourniquet. The newspaper describes it as, "one of the most deliberate and determined suicides on record."

Note: A great number of supporting technical references are included in the footnotes and chapter notes of Five Last Acts – The Exit Path (see also online: link at end of handout notes). But for readers who enjoy a more general, non-technical overview as a companion try, Lyle's "Forensics – A Guide for Writers" is an enjoyable paperback, written by a doctor, but sublimely free of technical jargon (Writer's Digest Books, 2008).

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[13] This is a simplified description. For a fuller explanation, please see Stapczynski J, *Strangulation Injuries,* Emerg Med 2010;31(17), (available online, www.emreports.com).
[14] North Hykeham double death, Lincolnshire Echo 5 Jan 2012.

PVS?

The tightened tourniquet alone stops oxygen reaching the brain, enough to produce unconsciousness which is then followed by death of the brain. As it dies, the brain swells and haemorrhages, also destroying the brain stem (located at the base of the brain, controlling automatic functions even in unconsciousness and permanent vegetative state). Yet the neurology is complex and difficult to observe directly. It has been argued by some that, in very exceptional cases of strangulation, the brain stem could survive as it has a separate blood supply.[15] There are rare[16] but reported cases of strangulation in healthy people where the brain stem has survived and the person remained permanently unconscious in PVS.[17] So it has been argued by some people that a sensible additional precaution might be to place a small to medium bag over the head with the ligature over the top. This will ensure breathing stops and making it impossible for the brain stem to survive. The roasting bags used in the helium chapter for making helium hoods are quite sufficient. Further research is needed to understand why all the available documented cases of suicidal compression without any bag have clearly resulted in death rather than PVS. The rare instances where PVS has occurred that have so far been noted have all been in cases of *temporary* compression – such as when one person tries to strangle another person,[18] other cases of temporary pressure such as the children's 'choking game' (used to create a temporary 'high' from depleted oxygen),[19] or neck restraints that used to be used in policing.[20]

Examination of available data and discussions with one of the world's leading neurologists, persuades the present author that a plastic bag is almost undoubtedly unnecessary. A key difference between temporary (attempted homicide) and prolonged compression (self-deliverance tourniquet) is that, with the latter, blood cannot flow out of the brain, so the intercranial pressure is not only maintained but increases. PVS is exceedingly rare in cases of temporary pressure, but in cases of tourniquet death, there is a specific prolongation of the damage to the brain. The resultant, extensive herniation is thought to be a main factor in the irreparable damage to the brain stem.[21] Brainstem damage is a huge concern where there is swelling or bleeding in the brain, because the brain has nowhere to expand other than down into the brainstem area.

(For further notes on brain herniation with this method of self-deliverance, please see the chapters in Five Last Acts – The Exit Path).

Circle of Willis?

The left and right common carotid arteries are the major arteries that supply the head and neck with oxygenated blood; they divide in the neck to form the external and internal carotid arteries. The carotids are located near the front of your neck and are what you feel when you take your pulse just under your jaw. There are also vertebral arteries, which join to form the basilar artery,

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[15] This idea was put forward by an anaesthiologist on the ERGO right-to-die news list. Research by Exit demonstrates that the possibility of it happening is so remote as to probably be discounted. As use of the compression method is not yet mainstream in the right-to-die movement, a section on using the additional plastic bag is nevertheless included in this chapter.

[16] Becker R, Sure U, Petermeyer M, Bertalanffy H, *Continuous infusion alleviates autonomic dysfunction in patients with severe supraspinal spasticity*, J Neurol Neurosug Psychiatry 1999;66:114, gives one such case of a 33-yr-old woman in PVS after hypoxic brain injury originating from non-suicidal strangulation.

[17] For a description of PVS (Persistent Vegetative State), see, for instance:
Multi-Society Task Force on PVS, Medical Aspects of the Persistent Vegetative State, NEJM 1994;330(21):1499-1508. The cases involved were not suicides or self-deliverances.

[18] Simpson R, Goodman J, Rouah E, Caraway N, Baskin D, *Late neuropathological consequences of strangulation,* Resuscitation 1987;15(3):171-85. Details the case of a young man who was a victim of strangulation. After hospitalisation, he survived nearly 5 months in PVS before succumbed to pneumonia.

[19] McClave J, Russell P, Lyren A, O'Riordan M,Bass N, *The Choking Game: Physician Perspectives,* Pediatrics 2010;125;82-87, p83.

[20] Hall C, Butler C, TR-03-2007 *National Study On Neck Restraints in Policing,* Canadian Police Research Centre 2007. http://www.wildgeesema.com/Neck_Restraints_in_Policing.pdf accessed 2 July 2012.

[21] *See also, for instance:* "Brain herniation is a condition in which a portion of the brain is displaced because of increased intercranial pressure, resulting in progressive damage to brain tissue that may include life-threatening damage to the brain stem." American Academy of Orthopaedic Surgeons, American College of Emergency Physicians, Critical Care Transport, Jones and Bartlett 2004, p.407.

which supplies blood to the brainstem, and also connect to the Circle of Willis to potentially supply the rest of the brain if there is compromise to one of the carotids.

But the Circle of Willis – an arterial circle at the base of the brain – not only varies anatomically from one individual to another and is often incomplete[22] – but could at most, and only that much in some cases, compensate for the occlusion of just one of the carotid arteries,[23] and is only there to compensate for minor occlusions. This is because the carotid arteries each contribute about 40% of the brain's required blood supply. Only the remaining 20% goes through the vertebral arteries through the base of skull. So occlusion of both carotid arteries, as in ligature compression, is more than can reasonably be compensated for by the Circle of Willis, which needs to maintain blood pressure at 50 per cent of normal to prevent death of brain tissue.[24]

Survival after strangulation attempts is not uncommon; whereas with ligature compression, the cause of brain damage is maintained until death occurs.

Neither does there need to be total blood stoppage. Several authors have suggested that watershed infarcts also occur in cases of carotid occlusion (tissue death caused by insufficient blood supply at neighbouring areas, much like lack of irrigation at the most distant parts of agricultural fields).[25] But from brain death to brain stem death, a number of factors come into play separately or together. Several of these are a result of changes in the brain. Direct hypoxic damage affects the cortex more than the brain stem. But continued compression from the ligature (not present in strangulation cases where the compression is only temporary) maintains any increase in venous pressure, which, together with changes associated with tissue death in the brain and resultant haemorrhages, can cause 'coning' – a resulting swelling (oedema). In short, various physical pressures from the brain itself impact the brain stem and make its survival unlikely.[26] But how to pin down the exact sequence of events? A bit like launching a rocket-propelled grenade into a house and asking what causes the house to collapse – was it the fire? The air pressure from the explosion? The initial or subsequent damage to the structure? Theory, experience and common sense says it works, but the experimental hurdles to determine the exact mechanism may be hard to arrange. Similarly, it is difficult to imagine persons undergoing a brain scan while performing self-deliverance ligature compression.

How long?

One should ensure a minimum of twenty minutes without possibility of being disturbed.

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[22] *See, for instance,* Bergman R, Afifi A, Miyauchi R, Circle of Willis, in: *Illustrated Encyclopedia of Human Anatomic Variation,* at http://www.anatomyatlases.org/AnatomicVariants/Cardiovascular/Text/Arteries/CircleofWillis.shtml accessed on 4 July 2012.

[23] *See for instance,* Tortori-Donati P, Rossi A, Biancheri R, Pediatric *Neuroradiology: Head and neck, spine,* Springer 2005; p943.

[24] McCaffrey P, Neuroscience on the Web, http://www.csuchico.edu/~pmccaffrey//syllabi/CMSD%20320/362unit11.html accessed 4 July 2012

[25] Hypoxic-Ischemic Brain Damage, In: Rabinstein A, Resnick S, *Practical Neuroimaging in Stroke,* Saunders 2010, p.12.

[26] Pallis C, *ABC of Brain Stem Death: From Brain Death to Brain Stem Death,* BMJ 1982;285:1487-1490. For instance: p.1489 "Direct hypoxic damage affects the cortex more than the brain stem." And then (1489-1490), "Intracranial hypertension is also a feature of the cerebral oedema that almost invariably complicates acute anoxic insults to the brain. The initial effects, in such cases, are often complicated by the development of various intracranial 'shifts.' There may be downward-spreading oedema and caudal displacement of the diencephalon and brain stem with stretching of the perforating pontine branches of the basilar artery and secondary haemorrhages in their territory. Or the brain stem may be compressed from uncal herniation into the tentorial opening." Several other damage routes are listed.

Is it suitable for anyone?
In theory yes, but in practice, about 50% of persons attending a full-day interactive workshop rehearsals felt fully confident about using the method whereas others seemed nervous or puzzled about applying the ligature.

The space between ligature and rod must be enough to allow tightening but not so much that there is a massive number of turns. The tourniquet high up on the neck to minimize uncomfortable pressure on the windpipe and maximise pressure on the carotids.

The process should be completed quickly! Failure to do this results in compressing the veins before compressing the arteries. Although it would 'work' just as well, to avoid discomfort the arteries need to be compressed quickly. Otherwise there is blood flowing in and not flowing out and it creates a slightly unpleasant sensation of fullness.

Index

5

5HT3-receptor agonists 38

A

academic convention..... 8
accurate transmission ...12
acetaminophen 5
acknowledging differences 7
ad hominem 6
adjusting flow..... 7
aircraft piloting.....2, 11
anti-emetics..... 14, 33
antihistamines.....37
areas of expertise.....11
attitude of mind.....34
audible flow.....22

B

barbiturates.....10
benzodiazepines..... 30, 31
best of intentions 9
blame game 11
Boudewijn Chabot 28
brain hemorrhage..... 6
brain stem 27
brainstorm..... 3
bungee cords.....20

C

camaradie.....17
carbon dioxide ...21, 22, 31
Chicago Seminar.....14
chloroquine . 10, 12, 19, 30
chlorpromazine 37, 38
Circle of Willis 26
collaboration 36
combination anti-emetics 33
common fallacies 5
common interest..... 4
commonality 6
commonality of interest.. 4
communication.....34
complex methods.....10
complexity..... 13, 20
Compression 19, 34
conflicting data 3
consistent composition .30
correspondence.....36
criticism 8

D

Departing Drugs 31
Derek Humphry 14
detergent suicide 30
Dick Côté.....14
different authors.....6
different viewpoints.....7
dilemmas.....9
discretely hidden 23
discretion 8
distress..... 11
distributing self-deliverance material. 12
dizzy point 26, 27
domperidone 33, 37
dopamine blockers 37
drawing conclusions 8
dress rehearsals17, 18, 25, 27
drugs + plastic bag asphyxia.....6

E

emergency method 19
enduring harm 19
enquiries.....36
enthusiasm 11
Ernest Hemingway.....30
error 12
errors of dissemination 10
errors of logic.....12
ethical scrutiny 11
examine differences 3
existing ideas.....16
exit bag.....17
Exit International..... 16

F

failure rate 18
failures 8
fainting.....26
falsifiability..... 8, 12
fasting.....28
Faye Girsh..... 14
firearms 14, 34
flammable gas 12
Fleischmann.....25
flow control valve..... 7, 23
Fogelin.....5, 7
follow-up discussion 11
founder of Exit 15
Frankl.....34
friendships.....3

G

gaiety.....23
game theory 13
gas flow regulator..... 22
George Mair..... 15
Gladd Bag 23
good faith 6
guns 30

H

hand-out..... 26
hand-outs..... 15
hasty generalizations..... 5
heart attack..... 27
helium ... 10, 12, 16, 17, 18, 30, 34
helium hood.....20, 23
helium nozzle..... 23
high reliability 12
highest authority.....6
honest behaviour 11
hospitalised..... 18
hydrogen sulphide..... 5, 14
hypercapnic response.. 21, 31

I

immobilised sleep..... 32
intractable arguments. 4, 6
intractable differences..... 7

J

Jerry Metz 30
jumping on the bandwagon 5

K

knock-down effect..... 30
KSAs 2, 11, 13

L

legal guidance 12
ligature compression6, 14, 17, 25
ligature compression by a third party 6

M

martial arts 26
mental or physical infirmity 13
methodology 16
metoclopramide33, 37, 38, 39
moment of death 21, 34
multidisciplinary level..... 12

N

new methods..... 16
non-science.....8
normal arguments 4
NuTech.....2

O

ondansetron 38
one-to-one advice..... 36

Oregon 4
originating authors 11
oxygen 31
oxygenated blood 25
oxygen-permeable 31

P

panic attack 21
paracetamol 5
paralysed 19
pathology 26
pharmacokinetics 10
phenothiazine 37
philosophy of science 8
plastic-bag-and-drugs 8
Popper 8, 11
practical applicability 12
priorities 7
privacy 16, 18
probity 11
productive differences 7
promethazine 37
PVS 6, 26

Q

questions of fact 7

R

ready-to-use kit 23
refusal-of-food-and-liquids 11
reliability 11, 13, 18
responses 36
right to die 15
rufflette 26
rules of thumb 13
Russel Ogden 21
Ruth von Fuchs 23

S

scientific method 3, 7, 8, 11
scrunching 22
setting standards 11
shared beliefs 4
shared preferences 4
sharing of criticism 6
signature suicides 30
silicone tape 23
sleeping pills 19
social science 3
Socratic tradition 8
sting in the tail 10
stroke 18
suffering 15
suicide in hospital 27
swallow many tablets 16
Swedish tap turner 22
swollen feeling 25

T

tablets 17
Tannen 9
tap-turner 7
technical arguments 5
technical detail 11
time 6
time pressures 11
too complicated 30
tourniquet 25
translations 10
Turner 4
two tanks 23
two tubes 21
two-way conversation 11
type of plastic 31

U

unintended consequences 10
unspoken assumptions 4

V

vagal inhibition 27
video presentations 10

W

widespread discussion 10
windpipe 25
workshops 6, 7, 9, 16, 17
worry 10

References and notes

(for handouts sections, please see the respective footnotes*)*

1 My thanks go to Derek Humphry who sponsored this seminar.

2 Helmreich R, Merritt C, *Culture at Work in Aviation and Medicine: National, Organizational, and Professional Influences.* Brookfield, VT: Ashgate; 1998.

3 Baker D, Day R, Salas E, Teamwork as an Essential Component of High-Reliability Organizations, Health Serv Res 2006; 41(4 Pt 2):1576–1598. doi: 10.1111/j.1475-6773.2006.00566.x (full text).

4 http://www.euthanasia.cc/pdf/citations.htm

5 by Dale Turner: it can be downloaded from: http://ojs.ed.uiuc.edu/index.php/pes/article/download/1543/281 Turner D, *Critical Thinking and Intractable Disagreement,* Philosophy of Education 2006:224-232 (an ojs publication of the University of Illinois). Turner's paper is fairly accessible, but for those that enjoy an approach based more in formal logic, see: Robert Fogelin R, *The Logic of Deep Disagreements,* (reprinted in) Informal Logic 25(1);2005:3-11 online pdf at http://tinyurl.com/kukhu23; and also Godden D, Brenner W, *Wittgenstein and the Logic of Deep Disagreement,* Cogency 2(2); 2010:41-80 online pdf at http://tinyurl.com/nvdy4c6 In refining the scientific approach, I am also calling on the logic of falsifiability developed by Karl Popper, and which is available from many sources. A purely philosophical basis traces back to Wittgenstein and his essay, *On Certainty.*

6 Makau J, Marty D, *Cooperative Argumentation: A Model for Deliberative Community,* Waveland Press 2001. It is also available as an e-book or can be searched to an extent free online at http://tinyurl.com/qa45t97.

7 The reference being to *Five Last Acts – The Exit Path* (752 pages), and even though my previous book at 414 pages had already been described by the World Federation newsletter as marking "what may be the most comprehensive guide to self-deliverance techniques available."

8 In self-deliverance, we are not so much "representing a particular position" other than one of scientific method. Why is this important? Because intractable disagreements often arise not because of our aims, but because of our position as a specific

organization. To make progress in the face of such a situation is to examine the two positions rationally. Only by first examining and respecting differences can we then proceed to build on the reality that everything rests on how much is shared to begin with (rather than what we assume is shared to begin with).

[9] This example is simplified from Fogelin, *vide supra.* Successive rejoinders can be added, each of which changes the conclusion.

[10] *A Treatise of Human Nature* by David Hume, published in 1738. The discussion that Fogelin refers to is Book One, Part Three, Section 13.

[11] Hasty generalization is an informal fallacy of faulty generalization by reaching an inductive generalization based on insufficient evidence – essentially making a hasty conclusion without considering all of the variables. In statistics, it may involve basing broad conclusions regarding the statistics of a survey from a small sample group that fails to sufficiently represent an entire population. In medicine, it may be a conclusion based on an insufficient number of studies, adding assumptions outside of one's specialized knowledge, or not considering a question in sufficient depth. The person committing the fallacy is misusing the following type of reasoning: X% of all *observed* As are Bs. Therefore X% of all As are Bs.

[12] Exit, 17 Hart Street, Edinburgh, Scotland U.K. Not connected with any other group that has a similar or same name, including 'Exit International.' Exit is completely independent and not a member of the World Federation.

[13] Apart from an occasional small item in the BMJ if that counts, my last published academic work was in 1996 in the Dartmouth series, such as *Contemporary Issues in Law, Medicine and Ethics* or *Death, Dying and the Law.* My last published chapters for the legal profession were in volumes such as *Health Services Law and Practice* in 2001. I work for Exit full time with a priority on self-deliverance.

[14] First published in: The International Drugs Consensus Working Party, *Departing Drugs* 1993 (U.K., Canada, Germany, Spain and Netherlands).

[15] Of *Exit International* (no connection with Exit).

[16] ibidem p.6

[17] originally published in Docker C, Smith C, and the International Drugs Consensus Working Party, *Departing Drugs* 1993. Subsequently in the *Five Last Acts* series and also mentioned later in this paper.

[18] Tannen D, *Agonism in academic discourse,* Journal of Pragmatics 34;2002:1651-1669
http://faculty.georgetown.edu/tannend/pdfs/agonism_in_academic_discourse.pdf

[19] Tannen *ibid.,* 1655.

[20] I have done so in a separate section of *Five Last Acts – The Exit Path* in order to respond in detail concerning technical considerations of benzodiazepines and a number of other matters.

[21] For those that are interested, there are useful and parallel management principles. 1) An idea is brought to the board, which then approves it or returns it for further analysis. This is comparable to the *initial research* stage. 2) Then there occurs intra-organisation transmission in which the board defines he rules governing its interaction with other parts of the corporate body, such as the staff – via the chief executive. This is comparable to the stage where self-deliverance research is shared with another organisation. 3) Thirdly there is the way in which the board monitors the results of its actions and policies, frequently using the format *What benefits? To whom? At what cost?* This is comparable to a transmission stage where the research is then used by someone to end their life. (Exit's board process is based on the *Carver System of Policy Governance.* For some guides, see: http://policygovernance.com/guides.htm and for the overall philosophy see many textbooks or the source at http://policygovernance.com/)

[22] Although too complex to cover here, the broad points are dealt with in a later section of this paper.

[23] At least one very recent study shows that persons in an audience absorb material more effectively in the situation where the speaker provides hand-outs and they can focus exclusively on what is being said, rather than trying to take notes at the same time. Long G, *Positive Effects of Restricting Student Note-Taking in a Capstone Psychology Course: Reducing the Demands of Divided Attention in the Classroom,* Teaching of Psychology 2014(41):340-344.

[24] This mostly applies to interpretations of aiding, abetting or assisting which sometimes may include merely being in the same room as the person engaging in self-deliverance (seen as 'encouragement'). Provision of literature may or may not be an offence and is covered by different types of law in different countries. Case examples, see: Huxtable R, *Assisted Suicide – We need to clarify the current legal compromise but preserve the lenient attitude,* BMJ 2004; 328(7448):1088–1089.

[25] Côté R, *In Search of Gentle Death: The Fight for Your Right to Die in Dignity, Corinthian* Books 2011.

[26] For anyone wanting a slightly shorter version, the earlier volume, *Five Last Acts II,* is perhaps a more manageable size at 414 pages, and contains much of the same information but without such extensive analysis.

[27] I have moved what was mostly, or would have been given more time, Section 4 of the seminar to the first half of this 'print' version and called it, "Developing Cooperative Dialogues."

[28] Mair G, *How to Die With Dignity,* privately published by Exit (Scottish Exit) 1980. Dr Mair's book was the first of its kind in the world. Exit separated from its parent society in London in order to publish. Other notable founders included Sheila Little.

[29] LXXVII

[30] All these positions are linked with autonomy safeguards. Sometimes it is trimmed down to what the political situation will accept, as in Oregon, even though "terminally ill" misses many of the prominent persons wanting legal change for themselves due to multiple sclerosis or other not-immediately-terminal conditions. So the societies move to an ideal position of "unbearable and unrelievable"– one I have often supported. Yet now we have a growing movement advocating a right to "elder suicide" even if the person wanting to die is not suffering unbearably, and the arguments are quite convincing. So we come back to autonomy.

[31] In other words, nothing that anyone can say or do will deter them.

[32] It can be argued that this can discourage suicide, and hence the reducing the means of painless suicide can reduce suicide or, as some argue, even the knowledge of the means. Although this does not alter the question posed about someone who has indeed made an unshakeable decision to end his or her life, it is a serious question, and I have spent some time addressing ethical concerns regarding publication in a chapter of my recent book.

[33] Mair G, How to Die With Dignity 1980.

[34] For various reasons in this essay version, I have moved examination of the scientific method to the preceding section.

[35] EXIT workshops are being phased out at the moment due to lack of finances and other resources. We are hoping to make a DVD (fingers crossed! donations welcome!) that will allow people to explore the unique Exit way of learning self-deliverance.

[36] For the more exhaustive treatment, readers may want to peruse the corresponding book mentioned above, *Five Last Acts – The Exit Path* (http://www.amazon.com/dp/1482594099) although as already pointed out in this essay, no treatment is 'exhaustive.' In the case of Exit, this is not just a saying any more than elsewhere: there is a large backlog of new material and methods in the Exit office that simply needs the time to filter, analyse, check, and properly present.

[37] When we look at the credible accounts, one explanation that might seem to fit all the facts is adulterated helium. This, the manufacturers repeatedly assure, would never happen. Someone keen to spend several hundreds of pounds might wish to purchase a customized gas analyzer to measure purity and put 'conspiracy theories' to rest.

[38] Sikter A, Frecska E, Braun I, Gonda X, Rihmer Z, *The role of hyperventilation - hypocapnia in the pathomechanism of panic disorder,* Rev. Bras. Psiquiatr. 29(4);2007:375-379. http://dx.doi.org/10.1590/S1516-44462006005000048

[39] Scroll to the bottom of the Blog at http://exiteuthanasia.wordpress.com/ or download directly from http://exiteuthanasia.files.wordpress.com/2013/11/when-it-all-comes-to-an-end.pdf

[40] This is only a slight over-simplification: the relevant CO_2 receptors are different in sleep and in waking, and in sleep the motor reaction can be entirely unconscious, controlled by the brain stem; but the effects, an (almost) automatic desire to get more air by removing any obstruction, is similar. Hypercapnic response while unconscious is an important point when considering the bags+drugs method later in this essay. For a fuller description of how the process works, see: Kryger M, Roth T, Dement W, *Principles and Practice of Sleep Medicine,* 5th edition, Elsevier 2011.

[41] Main image: (main symptoms of carbon dioxide). Häggström, Mikael. *"Medical gallery of Mikael Häggström 2014".* Wikiversity Journal of Medicine 1 (2). DOI:10.15347/wjm/2014.008. ISSN 20018762. Image is in the public domain.

[42] We recommend doing this in front of a mirror in a dress rehearsal a couple of times. In workshops, some people thought they were squeezing the air out of the bag when in fact they were just squeezing the bag and pushing it to the back of their head.

[43] If you don't like the tap turner for whatever reason, but find the small metal taps unpleasant to grip and turn, try adding 'Sugru.'®

[44] Of Right to Die Society of Canada. http://www.righttodie.ca/bio-ruthvonfuchs.html

[45] The tourniquet is one of several of the compression methods we look at in workshops and books. Continuous looping, ratchet tie-down, and partial suspension are others that crop up in the literature. When a soft flat tie such as rufflette is unavailable, padding can be used without stopping the effectiveness. The pressure must be high on the neck to avoid unbearable discomfort on the windpipe. See our online citations at and also recently (purely for the pathology) Furukawa S, Sakaguch I, Morita S et al, *Suicidal ligature strangulation without an auxiliary mechanism. Reports of two cases with a cotton rope or a T-shirt and staining results of the brains using anti HSP-70, CIRBP, RBM3, HIF1-a, SIRT 1 and p53 antibodies,* Rom J Leg Med 2013ev;21:9-14. DOI: 10.4323/rjlm.2013.9.

[46] Tweedie a (ed) *A System of Practical Medicine* Vol III, Whittaker and Co 1840, p.233. The chapter on Asphyxia gives extensive descriptions of different types of compression both from experiment and pathology.

[47] A quick online explanation of vagal inhibition can be seen here: http://healthdrip.com/vagal-inhibition/ For a more detailed description please see Exit's publications or the relevant medical textbooks.

[48] "The Art and Science of Fasting: Abstinence from Food and Drink as a Means of Accelerating Death" in: Docker C, Smith C, Hofsess J, Dunn B, *Beyond Final Exit* RTDSC 1995.

[49] A personal story of experience with dehydration included in the seminar is omitted here. I will maybe add it in a later version.

[50] Paradoxically, in India, a country where suicide itself is still illegal, persons develop a useful community knowledge of the process within the Jain community. This provides not only essential knowledge of what to expect (in terms of physical degeneration) but also the tremendous emotional pressures and need for support from those nearby – a factor that Chabot also acknowledges.

[51] Exit Newsletter 2014;34(1).

[52] There are cases, for instance, when people have survived even with half their face blown off.

[53] I seem to have omitted a chart I had for the seminar. It will maybe be added to a later version of this e-file.

[54] Considerably aided in this instance by my longtime friend and associate, and a founding member not only of Exit but of the idea of a "how-to-die" manual, Dr Colin Brewer . . .

[55] See the various reference textbooks covering sleep apnea.

[56] See, "Night flight to eternal sleep? Benzodiazepines, Z-drugs, and the way we sleep" in: *Five Last Acts – The Exit Path*:469-473.

[57] Note that an earlier classification subdivided N3 into two stages. The distinction was abandoned due to lack of sufficiently clear differences. Interested researchers may wish to examine the difference in the effect on sleep architecture between benzodiazepines and z-drugs.

[58] I remember Colin also tried to persuade us to do a full laboratory experiment using a live pig. Very scientific, but I objected, partly on cost grounds, but also I think on account of a certain yuck factor.

[59] The Oregon Death with Dignity Act: A Guidebook for Health Care (see illustration). http://www.ohsu.edu/xd/education/continuing-education/center-for-ethics/ethics-outreach/upload/Oregon-Death-with-Dignity-Act-Guidebook.pdf

[60] Frankl V, *Man's Search for Meaning,* Rider 2004:75 (originally published in 1946, in German, under the title, 'From Death-camp to Existentialism').

In accordance with British law, Exit does not engage in one-to-one advice on suicide methods. For academic questions, enquiries, discussion, collaboration or responses, comments and notifying us of any errors, please make reference to the appropriate section in "Five Last Acts – The Exit Path" if possible when corresponding. Reach us on exit@euthanasia.cc or Skype or Facetime

self-euthanasia, methods & dialogues

This small book is an exact copy of the notes prepared for a conference on self-euthanasia (sometimes called "self-deliverance" or "rational suicide") in Chicago U.S.A. in the late part of 2014, and issued in printed format after reqpeated requests.

Research in this area tends to be difficult to coordinate effectively and suggestions are made for protocols. The seminar notes also include an overview of current methods, scientific developments, limitations and areas under development, together with an index and appendices covering neurological and pharmaceutical issues in two of the more complex areas.

This small (50 page) handbook makes reference to the extensive (750 page) volume by the same author, the interactive full-day workshops that have been developed by Exit, a Scottish euthanasia research organisation, and the author's 35 years' experience in the field.

About the Author

Chris Docker holds a post-gradulate degree in Law & Ethics in Medicine. His cross-disciplinary studies in death and dying span the academic, legal and medical press as well as five books aimed at removing the fear of death with particular emphasis on empowering choice. Knowledge of how one can choose the time and manner of one's death is sought after by an increasingly large proportion of society. While many countries permit the open consideration of such wishes with doctors and professionals, many are still "left to their own devices", often undergoing a process of fear and uncertainty.

Docker's caring approach and technical expertise stems not simply from many years of full-time research in the field of self-euthanasia: he has also trained in suicide prevention and palliative care. His other areas of work have included advance medical directives. He is principally known world-wide for his research work in methods of suicide.

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